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LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with the
Department of Counseling and Family Sciences

The Utilization Of Recovery Oriented Care (U-ROC) Clinical Supervisor Training
Program and Evaluation

by

Nakisha Castillo, M.S

Project submitted in partial satisfaction of
the requirements for the degree of
Doctor of Marital and Family Therapy

June 2013

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ABBREVIATIONS

ATTC	Addiction Technology Transfer Center
AAMFT-CA	American Association of Marriage and Family Therapists CA Division
CA	California
CT	Connecticut
DMHAS	Department of Mental Health and Addiction Services
MNN	Madness Network News
MHSA	Mental Health Service Act
NFCMH	New Freedom Commission on Mental Health
RM	Recovery Model
ROC	Recovery Oriented Care
SI	Symbolic Interactionism
SAMHSA	Substance Abuse and Mental Health Services Administration
U-ROC	Utilization of Recovery Oriented Care

ABSTRACT OF FINAL PROJECT

The Utilization of Recovery Oriented Care (U-ROC) Clinical Supervisor

Training Program and Evaluation

by

Nakisha Castillo

Doctor of Marital and Family Therapy, School of Behavioral Health

Loma Linda University, June 2013

Dr. Winetta Baker, Chairperson

The utilization of Recovery Oriented Care (U-ROC) training program was developed based on a needs assessment conducted on clinical supervisors. The goal of the program was to provide a training program that would further enhance the development and supervisor knowledge in the utilization of recovery oriented care's (ROC) 10 principles in supervision. The training program addressed the needs of supervisors in the California Mental Health Service Act organizations that are using ROC in their supervision with supervisees. The program provided supervisors with information on the utilization of ROC principles in supervision. Supervisors typically follow various supervision models or therapeutic interventions. As new models and interventions are introduced into the field of behavioral health, supervisors are typically the ones that will assist in the dissemination of information and application of the model or intervention.

The following objectives and activities provided measureable outcomes to indicate the enhanced development and knowledge of the supervisor. These objectives were measured by results from the U-ROC multiple choice and self-report survey at 3 different time points (pre test, posttest, and one-month follow up). Upon completion of

the 4 hour U-ROC training, supervisors are (1) knowledgeable on the background of ROC and Mental Health Service Act (MHSA), the improvement in their knowledge in ROC prior to and after training will be indicated by a difference in scores on the pre and post test; (2) knowledgeable about the 10 principles and have identified at least one new way to apply the principles during supervision. (3) Discuss how the principles apply to the process of supervision. (4) Demonstrate through role-play their ability to utilize ROC principles in supervision. The training program evaluation is based on the U-ROC multiple choice test and self-report survey pre test, posttest, and one month follow up. The results of supervisors scores indicated to the evaluator that supervisors are able to (1) demonstrate that they are aware of the different principles and its meaning (2) utilize the principles in their supervision (3) have a greater knowledge of the application of the principles by implementing the various skills they learned from the training.

CHAPTER ONE

INTRODUCTION

The field of mental health has been around for decades. Many professionals have worked in the field and have contributed significantly to the various interventions, programs, and methods used to work with the 57.7 million individuals, that are diagnosed with a mental illness in America (US Census, 2005). Clinicians working in mental health already have a number of comprehensive approaches they can use when working with and treating underserved populations. In fact, the mental health field has been moving from a medical model to a path of recovery for the mentally ill and new ways of treating clients are being developed. During the last 6 years or more, one such way that is transforming the field of mental health in the state of California (CA), is the Recovery Oriented Care approach (ROC).

The CA mental health is being transformed through the Mental Health Service Act (MHSA) that was voted in 2004. Funding from MHSA allows for the development of programs that are geared to serving who we call clients; but who in the ROC approach are known as consumers. As the CA mental health system is changing, there needs to be a way to educate the clinicians on how to utilize ROC in their work with consumers. One such way is through clinical supervision. Currently supervisors are expected to learn ROC as supervisees are learning of ROC in their institutions. A parallel process is needed as the field of mental health is transforming.

To date, a consistent flow of how the ROC approach is used in supervision has not yet been formulized. Such a formulization is important, however, because the use of

ROC during supervision, may impact the maintenance and or solution of the problem the supervisee may have in treating a consumer. In order to understand ROC in supervision one must explore the meaning of the 10 principles and its application with the severely mentally ill (SMI) population. SMI can be defined “as a group of individuals that have a psychiatric disorder that results in their inability to function in their daily care” (Ruggeri, Leese, Thornicroft, Bisoffi, Tansella, p. 54, 2000). In order to have an understanding of how ROC is utilized, one needs to have a comprehensive understanding of what ROC is and its principles. This proposal discusses in detail ROC, supervision, development of the U-ROC clinical supervisor training program, as well as an evaluation of the training program.

CHAPTER TWO

PROBLEM STATEMENT

The target problem, for the purposes of this training program, is the need to have a research based training, for supervisors who work in MHSA funded organizations, which will inform supervisors on how to utilize the principles of ROC during their supervision. This group is targeted, as there are no studies related to how supervisors gain, incorporate and transfer knowledge of ROC principles. Effectively, if supervisors are not knowledgeable of the principles and its applications, supervisees will not learn the concepts that are needed in caring for their consumers.

The need for the training was developed based on prior needs assessment, which indicated that supervisors are unsure of how to apply ROC principles in their supervision. Through interviews and coding, the U-ROC supervision-training program was developed. The data collected, clearly indicated that a training program is needed in order for supervisors to have a foundation to work from, in supervision, on the application of the principles. Additionally, according to the interviews, the use of metaphors, role-playing and vignettes are necessary for supervisors to understand how to use principles to enhance their knowledge.

The aim of the ROC supervision training evaluation is to determine training effectiveness as evidenced by the change in the post-test and one month up results after

the four hour training program. The enhancement of supervisor's knowledge promotes increased confidence in their utilization of ROC principles.

In order to understand ROC in supervision, one must have a comprehensive understanding of the meaning of the 10 principles and its application with the severely mentally ill (SMI) population. The development of a training program based on a needs assessment will aid supervisors in applying the 10 principles of ROC in supervision. Currently there is one training workshop in the state of CA that addresses supervisor's use of ROC. An extension of that workshop is necessary for continued education of clinical supervision.

Target Population

The U-ROC Training Program for supervisors is specifically targeted towards the training of mental health supervisors, employed in a MHSA funded organization by the CA Department of Mental Health. In order for supervisors to participate in the U-ROC training program they must be conducting clinical supervision for Marriage and Family Therapy, Counseling and/or Social Work students or interns in a recovery-oriented treatment setting. These supervisors need to have supervised at least one trainee/intern who has worked with at least one severely mentally ill client within the last year. In addition to those who meet the inclusion criteria, the participants must be able to speak and understand English.

Supervisors help to shape and strengthen the knowledge that the supervisee needs in order to be an effective therapist (Itzhaky & Chopra, 2005). Supervisors are able to convey this based on the supervision model or approach that they utilize in exploring how the supervisees function with their client. The supervisor guides the supervisee in

developing goals for their clients, noting the progress of the client and to enhancing the learning of the supervisee (Davidson & Strauss, 1992). The supervisor is the key to learning and professional development (Holloway & Wolleat, 1994). Supervisors are there to foster the growth and development of the supervisees as well as evaluate their progress as a clinician (Bernard, 2005). Supervisors are placed in a major role in which they are able to influence the clinical, social, and professional development of supervisees (Greens and Dekkers, 2010).

Qualification to become a clinical supervisor in the state of California is determined by the state licensing body – The Board of Behavioral Sciences (BBS). Licensed psychiatrists, psychologists, clinical social workers and marriage and family therapists must all possess a current and valid California license for at least two years prior to beginning to supervise. These professionals must also have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers that perform psychotherapy as part of their clinical practice in two of the past five years immediately preceding the beginning of supervision. In addition, licensed clinical social workers and marriage and family therapists must also complete a 6-hour supervisor training course within two years of beginning to supervise. The supervision training course covers such topics as law and ethics as it relates to supervision, supervisor responsibilities, including forms and requirements for students and interns, and the incorporation of theory into supervisee learning (www.bbs.ca.gov).

Current Recovery Oriented Care Training Programs

Currently the Substance Abuse on Mental Health Service Administration (SAMHSA) offers free virtual 14-hour introduction training for the clinical supervisor on

ROC. The program is offered on the Addiction Technology Transfer Center (ATTC) developed by Dr. Talboy and the ATTC Network Clinical Supervision Workgroup, the Mid-America ATTC Regional Center, and the ATTC National Office. The program provides terms, topics, and resources for the supervisor to use in conceptualizing the use of ROC. The program does not specifically focus on the application of ROC principles in supervision.

Currently there is one training program in the state of CA that addresses the use of ROC in clinical supervision. The program was developed by the American Association of Marriage and Family Therapists CA Division (AAMFT-CA). The training was developed to respond to the training needs of supervisors who are evolving with the times of transformation in mental health. The goal of the program is to present a recovery oriented approach to clinical supervision. Developers hope that supervisors will be able to:

1. Explain how the Mental Health Services Act requires a paradigm shift to Recovery Oriented Care in public mental health treatment.
2. List the ten Recovery Principles and discuss their implementation within the clinician/consumer interactions.
3. Demonstrate Recovery Oriented supervision through active utilization of the concept of parallel process.
4. Discuss the concepts and challenges related to current public mental health documentation.

Purpose of a Training Program

As the mental health system is transforming through the MHSA, there is a need for training programs on how administrators, clinicians, supervisors, and policy makers can

incorporate the changes (Cohen, Abraham, Burk, & Stein, 2012). By having a training program, supervisors will be well-rounded in the knowledge of ROC and they will be prepared to help supervisees in understanding the meaning of ROC and what it means to work collaboratively with consumers in discovering their path to recovery (Cohen, Abraham, Burk, & Stein, 2012). As supervisors are making changes and adaptations to ROC principles, training would help to make that transformation smoother. It is important that supervisors have a full understanding of ROC approach. As the field of mental health transforms, ROC plays a crucial role in developing the cornerstone of training supervisees in becoming effective clinicians (Davidson, O'Connell, Tondora, Styron, & Kangas, 2006).

Development of the recovery oriented care supervisor training program for supervisors, is based on a need assessment, that uses a qualitative methodology to inquire how supervisors are training behavioral health students and interns, in the use of recovery-oriented treatment principles. Information gleaned from the needs assessment will be used in the development of a recovery-oriented supervisors training program. The program addresses the needs based on the assessment of how supervisors are incorporating ROC in their supervision.

The purpose of the ROC training program is to educate new and experienced supervisors on the 10 principles of ROC, also, to enhance their knowledge of ROC and how they can incorporate these components in their work with the underserved and neglected population. The use of ROC is new in the mental health system and most supervisors have not been offered trainings on how to fully implement these principles with their supervisees. By having this training, supervisors will be more efficient in their

work with the principles of ROC. Additionally, in receiving this training in the principles of ROC supervisors are more likely to increase their competence in the approach, which in turn leads to an increase in supervisee's competence and improved consumer care.

The training promotes the increase of supervisor's use of ROC and how they can best use different tools in supervision to help supervisee conceptualize ROC. Supervisors will walk away with an understanding of what recovery oriented care entails as well as how to apply the 10 principles, by utilizing various mechanism of how to enhance the incorporation of ROC. By supervisors improving their knowledge of ROC, it in turn leads to further development of the supervisee's understanding of ROC.

As the MHSA continues to transform students' learning objectives and maintain a strong foothold in the public mental health system, ROC is not only important but also essential for increased supervisor competence within this context. Ultimately, increased supervisor competence leads to increased clinician competence and conjointly, improved consumer care.

CHAPTER THREE

THEORETICAL FRAMEWORK

Theoretical frameworks are a collection of interrelated concepts that assist researcher in an explanation of particular phenomena and provide clarification on the topic in their study (Lavee & Dollahite, 1991). Theoretical framework is influential in guiding family scholars formulate ideas, helps to determine what factors to explore and measure, and how to theorize studies (Bengtson, Acock, Allen, Dillworth-Anderson, and Klein, 2005). Theorizing is significant in the uses of practice. Theory can provide a structure of reference for organizing our observation and assessment of the individuals that clinicians interact with. Additionally, theory is a set of concepts that justify client and clinician experiences, and an instrument for predicting patterns of action (Gitterman, 1988).

In the area of supervision theory helps guide the supervisor on how they conceptualize cases and train their interns (Todd & Storm, 2002). To date there is no literature on how supervisors apply ROC approach in their supervision. In conceptualizing supervisor's use of ROC approach in supervision, Symbolic Interactionism (SI) is useful in addressing how supervisors use the principals of ROC approach during supervision.

Symbolic Interactionism

As a conceptual framework the author will detail the theoretical bases of symbolic interactionism (SI) and how it applies to the ROC study. A comprehensive review of the literature states that SI is a prevalent theoretical perspective that has guided research on

family interactions (LaRossa & Reitzes 1993; Clark, 1997). This theory has a systemic lens because it focuses on the interaction between individuals and others, as well as, how the environment they interact with plays a role in their lives. This is central to the work in the field of Marriage and Family Therapy (LaRossa & Reitzes, 1993; Walsh, 1995). One of the main concepts in the theory is that of symbols and the role they have in our everyday interactions. Symbols are objects or items such as “a word, nonverbal gesture, object, action, or style of appearance that by agreement is used to represent something else” (LaRossa & Reitzes, 1993; Frey & Sunwolf, 2004). The most common symbols are words, which are transmitted into language, and the way one communicates (LaRossa & Reitzes, 1993; Walsh, 1995). ?

According to Hewitt (2000), symbolic interactionism explains how individuals express their conceptualization of themselves; their interaction with what is real to them and others, and the way in which they carry themselves. The SI theory stresses the dynamic collaboration present between people and their social worlds, as well as the importance of personal meaning and the interpretative process of interaction (Blumer, 1969; Anglin, 2002). SI allows researchers to explore how people create meaning during their interactions as well as how the self is constructed and exists (Stkyer & Burke, 2000)?

Symbolic Interactionism and Recovery Oriented Care Approach

Supervision is characterized as the process by which clinicians develop (Bridges, 2005). During supervision clinicians learn the practical ways of how to conceptualize cases and have an awareness of themselves as professionals (Gilbert & Evans 2000). Clinical supervision is one of the most constructive ways in which interns can learn the

practical skills and professionalism that is needed to work with clients (Bernard & Goodyear, 2004).

The use of SI in the development of a training program for supervisor utilizing ROC principals in supervision can be linked to the questions that the theory asks. For example “what are the roles or societal expectation of a husband and wife” this question can be applied to the study when one looks at the role of the supervisor and the expectations that they have when interacting with their interns. By exploring how individuals interact with one another in their world and create meaning, we can apply that to the training program of how the interaction between supervisors and interns, help shape the world in which they interact with one another (LaRossa & Reitzes, 1993). Supervisors are the ones that create the environment in which the intern will enter and interact in during the period of supervision. In SI, the theory explores how a person creates meaning in their interaction, in their world (LaRossa & Reitzes, 1993). In the training program supervisors will learn how to apply the ROC’s 10 principles to supervision and how they arrive at the point of applying the principles. For example, what language do they use to convey the use of ROC? How do their values and beliefs in the use of ROC impact their interaction with their supervisee’s understanding of the principles?

Themes and Assumptions of Symbolic Interactionism

There are three major themes from which SI was developed and under those themes are several assumptions that reflect SI. The first theme explores the significance of meaning for human behavior. This theme is relevant when one takes into consideration the meaning of supervision and the strong influence that supervisors have on their interns.

During supervision, supervisors are able to transfer information on how to care for the mentally ill by using the ROC principles and conveying to the intern that consumers are the experts in their care (Cohen et al, 2012). The interaction between the supervisor and the intern is meaningful at the moment in which they are discussing the principles and together they are creating the way in which the principles are applied in supervision. It can be through the use of metaphors that the meaning is created or through language that the supervisor uses.

The second theme focuses on the development and significance of self-concepts, on the belief that “individuals are not born with a sense of self but develop self concepts through social interaction” (LaRossa & Reitzes, 1993). This theme speaks to the idea of the role that the supervisors play in supervision and how they apply the idea of ROC principles by using their “self” as a tool in utilizing the concepts. Whether the information they are using to convey the message is through personal experience or how they were trained in the approach. In addition to, what meaning are they constructing in the reality of supervision?

The third theme explores the assumption of “societal process and the relation between freedom and constraint”. This theme is relevant as one looks at the larger picture when studying the understanding of how supervisors utilize ROC principles in supervision for those that treat mentally ill consumers. Consumers with mental illness are often dehumanized from society and their freedom restrained (Jacobson & Greenley, 2001). The use of the 10 principles allows for consumers to fit back into society. One of the assumptions under this theme is that individuals are influenced by the larger society (LaRossa & Reitzes, 1993).

According to LaRossa & Reitzes (1993), SI borrowed Herbert Blumer's three premises in which they base their first theme and assumptions on. The following themes are: "(a) human beings act toward things/experiences on the basis of the meanings those things/experiences have for them, (b) the source of the meanings for things/experiences are derived from or arises out of social interaction with others, and (c) the meanings of things/experiences are handled in and modified through an interpretive process used by the individual in dealing with the things he/she encounters" (LaRossa, Reitzes, 1993; Hewitt, 2000). Each of these principles and assumptions of could be applied in the supervisor's use of ROC principles during supervision. Supervisors are able to articulate what they know to their interns based on their experiences and the knowledge that they have on the subject as well as create meaning at the same time. In addition, supervision is a process that deals with matters as supervisors encounter them, just as the SI assumption that "meanings of things/experiences are handled in and modified through an interpretive process used by the individual in dealing with the things he/she encounters" (LaRossa, 1999).

Application of Symbolic Interaction to Training Program

The theory of symbolic interactionism is a well-used theory in the field of family science. The use of SI in the in the development of a training program and evaluation using ROC principles is relevant in that it provides a basis for understanding the foundation of meaning that the supervisors share in their interview. It allows for meaning to change over time and give room for adaptability. With the use of the principles in supervision, it also allows for the researcher to understand how supervisors create meaning and share that meaning with their interns. It also has room for interpretation,

language, and thoughts, which assist researchers in developing themes from the data, shared by the supervisors.

Furthermore, because the theory leaves room for interaction, it allows for the needs of the supervisor to be shared based on their interaction with the approach and to express what their needs are in order to develop a training program based on supervisors needs. SI is beneficial for ROC because the theory attempts to understand the dynamics between supervisors and interns and their level of interaction. By understanding the interaction, one can be aware of how the principals are applied. Also, using SI leaves room for development of a program and use of methodology in the ROC approach, using this theory allows for the researcher to see the skills necessary for supervisors to utilize ROC as well as apply it during supervision.

CHAPTER FOUR

LITERATURE REVIEW

According to the U.S. Census Bureau (2005), there are an estimated 26.2% of Americans, ages 18 and older, about one in four adults, experiencing a diagnosable mental disorder in a given year. This figure translates to 57.7 million people. Mental disorders are the leading cause of disability in the United States (Regier, Narrow, Rae, Manderscheid, Locke, & Goodwin, 1993). Many people suffer from more than one mental disorder at a given time (Kessler, Chiu, Demler, & Walters, 2005). The field of mental health has been in existence for decades and serves the purpose of providing care for individuals with mental illness. For decades the field of mental health has been serving individuals with mental illnesses and working from a medical model in which professionals prescribed the symptoms and treatment (Itzhaky & Chopra, 2005). Over the last two decades there has been a transformation in how clinicians care for their clients (Borg & Kristiana, 2004). This transformation encourages clinicians to work collaboratively with their clients in treatment on a path to recovery (Borg & Kristiana, 2004). In order for the mental health system to make this shift, the CA MHSA funded programs was developed. Programs that use MHSA funding are expected to use the ROC approach in their work with clients. One training program in the state of CA is not sufficient to train all the mental health professions. One way in which clinicians can learn the utilization of the ROC principles is during supervision. Supervision is used as a place for learning beyond the classroom and seen as an ongoing training process.

In this literature review the writer will allow the reader to have an overview of ROC as well as the history and development of ROC and the principles. In trying to fully conceptualize ROC the writer found that in the literature there is confusion on the development of ROC. The importance of supervision will be discussed to inform the reader of how ROC principles can be disseminated through supervision. This review will also delineate the key components in developing and evaluating a training program for clinical supervisors.

Recovery Oriented Care

It is estimated that there are approximately 6.7 million of individuals living in the United States that are non-institutionalized that are living with a mental illness, of this 6.7 million, 2.4 million are children (Government Accountability Office, 2012). According to Crisp, Gelder, Rix, Meltzer, & Rowlands (2000), those that are living with a mental illness are highly stigmatized by society they are viewed as individuals that are not worth function in society, instead of being viewed as a person that has a dysfunction and trying to make it in society. Individuals with a mental illness often lack the skills deemed necessary to function in society such as social, employment, and communication skills (Levine, 2012). In order for a person to function in society, one has to be accepted and not be rejected. The purpose of ROC is to help consumers gain resiliency, rebound from their current situation, and to enhance growth through transformation of the individual (Onken, Craig, Ridgway, Ralph & Cook, n.d.). ROC was developed to assist those diagnosed with a mental illness to contend with their disability and to live a productive life without the stigma of the disorder. ROC is about inclusion and empowerment of the consumer (Cohen, Abraham, Burk, & Stein, 2012).

A new paradigm was being formed in the mental health field regarding the language used about consumers, beliefs regarding recovery and the clientele served, and the values portrayed by clinicians. Recovery Model (RM) is a reformation of how mental health institutions support the mentally ill toward self-care (Fardela, 2008). Recovery has been discussed for at least 20 years in several countries including Japan, Germany, Switzerland, Scotland, France, and the United States. Evidence has shown that those who have been diagnosed with serious mental disorders, such as schizophrenia or bipolar disorder, have been able to resume significant roles in their social setting. Dr. Robert P. Liberman, Professor of Psychiatry at UCLA School of Medicine, strongly suggests that people with long-term bouts of schizophrenia can recover. Furthermore, Liberman has observed that persons with schizophrenia can go long periods without experiencing psychotic episodes (Fisher & Ahern, n.d.).

The term recovery is used in many different areas and holds different meanings (Jacobson & Greenley, 2001). Based on the literature in the field of mental health where professionals are treating the serious mentally ill (SMI) (Levine, 2012), recovery is defined as a journey that is well rounded and includes the empowerment of consumers to be part of their treatment and productive members of society (Cohen, Abraham, Burk, & Stein, 2012; Song, Hsu, 2011). Part of the journey is to apply the 10 principles with the consumer. By doing so the consumer is able to be hopeful in their progression, monitor onsets of symptoms, learn ways of coping and managing their symptoms, and are educated on self care (Andersen, Oades, & Caputi, 2003; Anthony, Cohen, Farkas, & Gagne, 2003; Jenkins & carpenter-song, 2006; Kelly & Gamble, 2005, Spaniol, Wewiorski, Gagne, & Anthony, 2002). The idea is that the way consumers are cared for

in treatment is a collaborative agreement between the consumer and the professional (Cohen et al, 2012; Onken, Craig, Ridegway, Ralph & Cook, 2007; Turner- Crowson & Wallcraft, 2002).

The United States Substance Abuse and Mental Health Services Administration (SAMHSA) define mental health recovery as “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (Department of Health and Human Services, 2011). There are 10 principles that guide recovery-oriented work. These principles attempt to provide consumers with hope, responsibility, empowerment, respect, peer support, a strength-based perspective, a non-linear approach, and individualized and self-centered, self-directed and holistic care. According to Borg & Kristiansen (2004), when utilized, these principles represent a collaborative way of working between consumers and clinicians in which consumers are actively involved in their own recovery and professionals support and engage the consumer’s capacity towards recovery. ROC is a new way in which clinician can work with their consumers in understanding their experiences as well as practicing in a new paradigm (Cohen, Abraham, Burk, & Stein, 2012).

The current idea of ROC is not new to mental health. Over the years there has been development of how ROC can be used to best serve consumers, based on ongoing evaluations, feedback, and recommendations from both the consumers and the professionals that work in mental health (Jacobson & Greenley, 2001). There is a consistent theme in the literature that there is a revolutionary change occurring in the service delivery (Peebles, Mabe, Fenley, Buckley, Bruce, Narasimham, Frinks, & Williams, 2009) of how clinicians work with and care for clients with mental illness in

therapy. This revolution opens up opportunities for both experienced and inexperienced clinicians to serve consumers (Cohen et al, 2012).

As the approach is being used throughout the field of mental health, exactly how it is being done is not quite clear as consumers are unaware of what they should be expecting and clinician are unaware of what the outcomes should be (Jacobson, Greenley, 2001; Resnick, Rosenheck, & Lehman, 2004). This issue is one that is hard to fix, the developers of the approach have a hard time agreeing and focusing on one meaning or what are the needs of those that have a SMI (Drake, 2000; Bullock, Ensing, Alloy, & Weddle, 2000). The one thing that developers are in agreement to is that there is confusion as to how ROC applies (Davidson, et al, 2005). The approach emerged as one that encourages and supports the recovery of consumers and an empowerment experience for the consumer (Jacobson, 2000). There is confusion of the term recovery because it takes on different meanings based on the condition the person is facing as well as across providers. For example a counselor that works in addiction define recovery as the addict being able to overcome their addiction, meaning going back to the stage they were at prior to the addition (White, 1998). In order to fully conceptualize the ROC approach, one has to have a comprehensive understanding of the purpose and development of ROC.

History of Recovery Oriented Care Approach

Recovering from a mental illness is not a process that started in this decade but can be dated back to two decades (Harding, Brooks, Ashikaga, 1987; Houghton, 1982) when policy makers, those serving the mentally ill, and consumers reported that the way in which they were being treated, was not helpful in their progression of recovering or functionality in society (Deegan, 1988; Unzicker, 1989; Frese et al., 2001). The

development of ROC became present as practitioners thought of ways in which they can best serve consumers (Anthony, 1993; Davidson & Strauss, 1995; Mechanics, 1998).

When searching the literature there are multiple definitions as to what ROC means. This issue stems from when the approach began to develop, which can be dated back to the “international pilot study of schizophrenia during World War II” in 1967, since then there has been studies done throughout the world to understand what it means for a person to live with mental illness and how they cope (Davidson et al., 2005). The theme that runs through all the definitions, is that they are looking at how a person functions daily with the illness, as well as how to assist the person in reappearing back into society and society accepting the person back without stigmatizing the population (Resnick, Rosenheck, & Lehman, 2004). The gist of the term has changed in the last decade to mean how does the person “overcome the illness by ways of not living in poverty, being isolated, unemployed, loss of identity to self as well as society, and being able to have a control of themselves” (Chamberlin, 1978; Jacobson & Greenley, 2001).

Prior to the notion of ROC in the field of mental health, professionals followed the medical model. The medical model belief is that clients with a mental illness would not recovery and would overtime debilitate (Levine, 2012). As the need for a change in the system of how clients were being taking care of, the ROC approach began to be developed. The idea of ROC was not just being taken into consideration in the United States but across nations such as Canada, Europe, and Asian countries (Sowers, 2005). To understand how the model was developed a brief history will be discussed to help the reader fully conceptualize how ROC plays a role in the care for consumers.

The delivery of care for a person with mental illness has been around for decades. How the individual is cared for changes over time as new interventions and models are developed. One such intervention that has been developed to care for individuals with mental illness is ROC. The current idea of ROC is not new to the field of mental health over the years there has been development of how ROC can be best used to serve consumers, based on going evaluations, feedback, and recommendations from both the consumers and the professionals that work in mental health (Jacobson & Greenley, 2001).

ROC emerged in the nineteenth century in Ontario, Canada. Individuals incarcerated in the federal penitentiary who showed signs of psychiatric symptoms were placed in underground cells. In the mid 1800s the government recognized that these prisoners needed to have better and more secure accommodations. The Canadian government felt these “lunatics” and “idiots” should be housed in places like asylums. Another reason for the separate facilities was to protect the mentally ill from prejudice and abusive behavior displayed by people in the prison community (Fardella, 2008).

Staff members and their families were housed separately from the mentally ill prisoners within the asylums. Once the identified prisoners were segregated from the larger prison system the staff members and these prisoners became more attuned with each other. Eventually, the staff and prisoners participated in weekly recreational activities that included dances, sporting games like baseball, and outings. Documents from compiled hospital records indicate that the prisoners were even part of a brass band. Currently, in other countries like Germany, prisoners who have been identified as having a mental illness are still separated with inadequate care (Fardella, 2008; Knorad, 2002).

In Germany during World War II, mentally ill prisoners were not given the opportunity to enjoy a fuller life of recreational sports or extracurricular activities. Instead, individuals that were recognized as having a severe mental illness were killed. Jeffrey Masson along with his colleague Peter Breggin visited Germany in 1988 to speak at a conference regarding psychiatry's role during the holocaust in Nazi Germany. Masson and Breggin (2007) discovered that there were approximately 300,000 mentally ill patients murdered during the Third Reich dictatorship under Hitler from 1933 to 1945. Those were patients from four insane asylums in Berlin. As found in a document written by novelists and psychiatrist, Alfred Döblin, who gave an account of the killings. Officials from the Third Reich ordered the doctors in the asylums to create a list of the patients who had been housed there for at least five years, who they thought would not be able to be released, and who could not work enough to validate their treatment. These patients were later removed secretly from the asylum without their families being notified. The nurses and doctors who accompanied these patients were sworn to secrecy. The excuse given was that they had to make room in the asylum for those who needed surgery and physical assistance due to the war (Masson, 2007).

Eventually, the nursing staff was unable to uphold their oath of secrecy. It became too difficult for the nursing staff to continue hiding the truth from relatives who came to visit their confined family members on a weekly basis. In addition, the nursing staff had grown accustomed to these patients because they lived in the asylums with them. Cemeteries in Linz began to fill up with unexplained urns that held the remains of the mentally ill patients. Once the location was discovered, family members retrieved the urns that held their remains of their loved ones (Masson, 2007).

In North America during the nineteenth century the treatment and care of the mentally ill was guided by religious humanism, William Tuke and Dr. Philippe Pinel moving away from a medical model they based their therapeutic community on an approach that emphasized respect and care toward the psychiatric patients. Pinel defined insanity as a mental illness, which could be treated through cognitive behavioral therapy. His approach would increase the patient's level of self-control and decrease the need for the patient to be confined (Fardella, 2008).

During the 21st century transition occurred in the name from “asylum” to “mental health services.” One reason for the name change was to reframe attitudes and the approach used in the care of patients with mental health diagnoses and symptoms. ROC brought forth new ideas and concepts regarding the way these clients live their lives. The new philosophy that encompassed this change was later called the “Recovery Model (RM).” The transformation made by RM allowed clients to make choices and have a voice in regards to their transition toward wellness, as a member of their community. It also allowed them to understand and identify themselves as apart from the symptoms of the diagnosis. This transformation of mental health services fostered in the client an ability to become more resilient, bounce back, and move toward growth in spite of the mental illness. ROC also gave the client the opportunity to collaborate with mental health professionals regarding their ideas of self-care (Fardella, 2008; Onken et al., n.d).

Consumer Advocacy Movements

Beginning in the 1950's and 1960's “grassroots” groups were being developed in small pockets around the country that advocated for the rights of those that were institutionalized because of being SMI (Cohen et al, 2012). According to Turner &

TenHoor (1978), in the 1960's a deinstitutionalized advocacy movement (Chamberlin, 1990) was developed by consumers and relatives, to protest against the ways in which they or their family members were being cared for by the mental health system. This group showed their support in the deinstitutionalization of people with mental illness as well as shared their concerns with the service gap (Drake, Green, & Goldman, 2003).

In 1963 President Kennedy established the Community Mental Health Center Act that stated community mental health agencies were required to care for individuals that were recently institutionalized (Turner & TenHoor, 1978). In the late 1970's, community support programs began to be developed (Drake, Green, & Goldman, 2003) and in the 1980's, family members of consumers joined in the grassroots movement (Chamberlin, 1990) to show their support for their family member and push for the gap to be filled in caring for those with mental illness. Also in the 1980's, there was the consumer/survivor/ex-patient movement (Chamberlin, 1990).

According to Morrison (2000) and Chamberlin (1990), the history of the consumer/survivor/ex-patient movement in the United States can be divided into four main stages. The Early Years include the activities of the 1970's, when the movement began. The Middle Years evolved in the decade of the 1980's, when the movement achieved recognition and was partially co-opted and institutionalized. The Recent Years correspond to the 1990's, when the Americans with Disabilities Act redefined the playing field and radical challenges were launched in response to psychiatry's "Decade of the Brain (Frese, Stanley, Kress, & Vogel-Scibilia, 2001)." The Emerging Years can be projected into the new era of the 21st century, as coalitions form and old wounds heal in response to increased threats and oppression from the enemies of the movement.

The era of the 1970's, with its social climate of rights awareness and social justice, and its challenges to expert authority, abuse of power and institutional control, marks the emergence of a larger movement for human rights in the mental health system. The early years of the 89 movement are characterized by an increased awareness of the abuse of human rights in institutions, of the practice of psychiatry as social control, and of the inherent oppression of the psychiatric system to its workers as well as its patients/inmates (Porter, 1987; Omark, 1979). The growth of the movement included the exposure of abusive practices, the dissemination of dissident views in the field of mental health, and the promotion of rights protection for psychiatric patients, as well as the opportunity for development of a collective identity of dissenters from the mental health system (Loren, 1999).

The early efforts to bring dissenters into the open and claim a voice are documented in the movement's first publication, the Madness Network News (MNN). This newsletter began as a collaborative project by a group of disgruntled mental health workers and ex-patients in the San Francisco Bay Area in August 1972 (Chamberlin, 1990; Hirsch 1974), where radical activity in general was at a high level. Rights activism brought intense awareness of injustice and oppression, and a challenge to expert authority as well. The notion that mental patients were human beings with human rights was resonant with the public outcry about rights for women, blacks, homosexuals, the physically disabled, and other oppressed groups that were organizing for change (Scott, 1985; Scholinski, 1997). Stories of clients that were mistreated in psychic hospitals were published in the MNN, so that their voice can be heard and something can be done (Scott, 1985). Stories focused on what it felt like to be labeled crazy (Zinman, Harp, Budd,

1986). One of the major dissemination of information and informing the community of consumer advocacy and recovery was through the National Alliance for the Mental Ill (NAMI) that was developed in 1979 (Frese, Stanley, Kress, & Voegl-Scibilie, 2001). To date NAMI is still around and advocating for families that have a mental illness to receive service.

The 1980's were an era of letting the voices of clients being heard and the inclusion of clients in the mental health system (Scheff, 1999). This led to the creation of alternatives, in turn led to recognition and funding by bureaucrats at the national level. This development led to a further crisis, when centers gained funds and priorities were shaped by acceptability to funding streams. Survivor activism was partially co-opted by newly developing "consumer activism" and radical change agents saw their fellows transformed into mental health reformers (Chamberlin, 1990).

The 1990's were an era in which funds were being distributed to agencies to develop programs that would incorporate consumers in their care in sessions (Jacobson & Greenley, 2001). Funds were being used in program development, research, evaluation, and outcome research. According to Jacobson and Greenley (2001), in the 1990's, states where confronted by management care to reorganize the way in which they were spending their funds for mental services. It was through the various movements and challenges that the notion of ROC developed on ways to provide services for those with mental illness (Davidson, et al., 1999). Groups were being developed in agencies such as "consumer affair specialist" that specialized in how to treat consumers (Levine, 2001). Consumers were being recognized as individuals and part of their treatment plans (levine, 2001). Additionally, consumers were hired in mental health agencies to be part of

treatment teams and the development of programs to better serve the population (Everett, 2000).

This era also marks the “The Decade of the Brain” (U.S. Dept. of Health and Human Services 1999). “The Surgeon General’s Report on Mental Health” (U.S. DHHS, 1999) emphasized the advances of research in understanding and treating mental illness, and encouraged people to seek help as they would for any other illness. A major theme of the report was the reduction of stigma attached to mental illness; another was the importance of treatment and intervention to reduce the “disease burden” (U.S. DHHS 1999).

Through the different movements throughout the years, organizations were formed that demonstrated individuals with mental illness being capable of providing support to one another and advocating for personal rights and empowerment (Davidson, Chinman, Kloos, Weingarten, Stayner, & Tebes, 1999). In the 2000’s, more publicity was given to those with mental illness resulting in change of how consumers are cared for (Szazs, 2001). Not only has ROC been has grown publicity but also policies are being developed in agencies (Whitaker, 2002).

President’s New Freedom Commission on Mental Health

In the last two decades there has been a transformation in how clinicians care for their clients that have a mental illness (Jacobson & Greenley, 2001). This transformation became ever-present in April 2002, when President Bush developed the “Blue Ribbon Panel, The New Freedom Commission on Mental Health (NFCMH)” (Cohen, Abraham, Burk, & Stein, 2012; Peebles, et, al, 2009) that would explore service gaps in mental health and propose recommendations for filling those gaps (United States Department of

Health and Human Services, 2003). The commission grew out of President Bush's campaign, where he affirmed support for people with mental and physical disabilities, pledging to "tear down" barriers to equality that face many of the 54 million Americans with disabilities (National Institute of Mental Illness, 2002). The goal of president bush was to fulfill his commitment to eradicate the disparity for Americans with a mental illness and those with disabilities.

The commission membership consisted altogether of 22 members that met for approximately a year to conduct investigation and analysis of private and public provider (President's New Freedom Commission on Mental Health, 2003). Fifteen of the members were appointed by President Bush that included "providers, payers, administrators, and consumers and their family members. The secretary of health and Human Services designated seven ex official members, four of whom were chosen by their department heads and the Departments of Labor, Education, and Veterans Affairs appointed the last 3 (President's New Freedom Commission on Mental Health, 2003). The President directed the Commissioners to identify policies that could be implemented by Federal, State and local governments to maximize the utility of existing resources, improve coordination of treatments and services, and promote successful community integration for adults and children with a serious mental illness (President's New Freedom Commission on Mental Health, 2003).

The mission of the NFCMH was to conduct a thorough study of the United State (US) mental health service delivery system, including public and private sector providers, and to advise President Bush on methods of improving the system. The goal was that recommendations would be made to assist in the delivery of service to not only adults but

children that have a mental illness so that they can live freely and be a productive member of their milieu (President's New Freedom Commission on Mental Health, 2003). This study would be the first study that was conducted in the last twenty-five years on mental health service delivery (President's New Freedom Commission on Mental Health, 2003).

Recommendations that were made stated (1) those with mental illness be called consumers and not clients, (2) treatment plans look beyond the symptoms but at the person, (3) the clinician work collaboratively with the consumers, and (4) that there is a peer support group as well as inclusion of family members in treatment (Cohen, Abraham, Burk, & Stein, 2012; Peebles, et, al, 2009; Torrey, Rapp, Tosh, McNabb, & Ralph, 2005).

At the time of recommendation of recovery for consumers the following was the definition (President's New Freedom Commission on Mental Health, 2003) :

“Recovery the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.”

Over the years the definition of recovery has changed the latest updated version of what recovery was done in January of 2012 by SAMSHA. The SAMSHA definition was previously stated in the overview of ROC.

After the recommendations were given to President Bush and the recommendations were disseminated states in the US began to make movement in how they would use the recommendations of the NFCMH. These states included Wisconsin,

Ohio, Connecticut, and California (CA). The focus in this paper will be on the state of CA mental health service act.

Connecticut Development of Recovery Oriented Care

As mental health clinic began to move in the direction of adhering to the recommendations of NFMHC the state of Connecticut tried to develop the first Recovery Oriented Care approach in their clinics (Connecticut Department of Mental Health and Addiction Services, 2006) since then a number of various states have followed in their steps in implementing policy's and funding to provide services in recovery (Davidson, Tondora, O'Connell, Kirk, Rockholz, & Evans, 2007).

In the early 2000's the state of Connecticut (CT) Department of Mental Health and Addiction Services (DMHAS) took on the project of making their behavioral health care system one that is totally recovery (Davidson, Tandora, O'Connell, Kirk, Rockholz, & Evans, 2007). They took this project on prior to New Freedom Commission report. In order for the state to take on this project they had to change the way they cared for consumers. This was not a linear project but rather one that was systemic (Davidson et al, 2007). Their plan of changing the system included (a) having input from consumers on how to best serve them, (b) developing a vision that revolved around what it means to be in the recovery process, (c) developing training and educational programs to help people be more knowledgeable in the area, and (d) reformatting the structure of mental health systems (Tondora & Davidson, 2006). The developers of the program realized that in order for a true recovery to happen they needed to make a shift from using the medical model approach to one that encompassed consumers. In order for that to happen the state partnered with providers in the community, consumers, and Yale university program for

recovery and community health. Through this partnership and with the expertise of consumers, the first 9 of the 10 principles were developed (Davidson et al, 2007). These nine principles were then used to develop what ROC provider should language and use as a path to recovery for consumers (Bredregal, O'Connell, & Davidson, 2006).

California Mental Health Service Act

In CA there are more than two million children, adults and seniors that are affected by a potentially disabling mental illness every year. People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities (Mental Health Service Act, 2009). In 2002 CA State Senator, Sen. Darrell Stienberg saw a potential solution to the ongoing problem of service inequality to those that did not have the means for paying for services (Pir, 2009). In 2004, his Proposition 63 required a one percent tax on California millionaires to be directly designated to the State Department of Mental Health. This was approved by California voters and developed into the Mental Health Services Act (MHSA). The CA Mental Health Service Act (MHSA) came after the President's New Freedom Commission report recommendations (Felton, Cashin, & brown, 2009).

After the passage Proposition 63 was voted in 2005 its purpose was to increase funding for transforming the mental health service delivery in the state of CA. The Mental Health Services Act, taxes very wealthy people to bring hundreds of millions of new dollars to the mental health system in California (Scheffler & Adams, 2005; Pir, 2009). Funding for CA recovery program was voted to institute a 1% surtax earned by persons grossing over \$1,000,000 per year (Scheffler & Adams, 2005; Felton, Cashin, & Brown, 2009). The money is to be used for transformational activities in the state's public

mental health system and attempts to expand and renew the existing system with a focus on promoting more recovery-oriented programs (Scheffler and Adams 2005). MHSA was developed to assist those that are unserved and underserved. Individuals that fit this classification include those diagnosed with severe mental illnesses, e.g. schizophrenia and bipolar disorders, those who live in rural areas with limited access to mental health services and those who may face cultural and linguistic challenges in accessing mental health services (Jones, Hardiman, & Carpenter, 2007).

The new MHSA funding source created tremendous opportunities for transforming mental health services delivery based on a humanistic approach to promote human rights and justice (Felton, Cashin, & Brown, 2009). This transformation created many opportunities for reducing disparity in more ways than one; including underserved ethnic, multicultural groups (Pir, 2009). MHSA, have begun to transform the California public mental health system through the implementation of ROC principles that was developed by SAMSHA, which focus on client-centered treatment (SAMSHA, 2005; Pir, 2009).

The MHSA specifically states, “Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers which (Mental Health Services Act 2004):

1. Promote concepts key to the recovery for individuals who have mental illness:
hope, personal empowerment, respect, social connections, self-responsibility, and self-determination
2. Promote consumer-operated services as a way to support recovery;
3. Reflect the cultural, ethnic and racial diversity of mental health consumers;

4. Plan for each consumer's individual needs.''

According to the Mental Health Service Act (2009), the funding that is provided serves the purpose of developing innovative programs that are geared towards care for minors, adults, and the geriatric population that has a mental disability. The programs shall have the following purposes (Mental Health Service Act, 2009):

1. To increase access to underserved groups.
2. To increase the quality of services, including better outcomes.
3. To promote interagency collaboration.
4. To increase access to services.

Programs would receive funding based on its purpose and approval of the Mental Health Services Oversight and Accountability Commission.

In order to develop innovative programs MHSA divided its funding MHSA into five main funding categories: Community Services and Supports, Workforce, Education and Training, Capital Facilities and Information Technology, Prevention and Early Intervention, and Innovation (Felton, Cashin & Brown, 2010). MHSA, takes on the Development of programs that has a model of do "whatever it takes" to work collaboratively with consumers and families to meet individual recovery goals (Cashin, Scheffler, Felton, Adams, & Miller, 2008).

In CA, programs are being developed for mental health workers to follow the MHSA motto of doing "whatever it takes" to serve the consumer, how exactly it is being done, is unclear. There is ongoing research as to how the different funding programs are being utilized to serve the consumer but not necessarily how they are serving consumer. In order for the MHSA programs to continue to serve consumers more research needs to

be done on how clinicians are serving consumers in order to develop a training programs. There are 10 core principles in which ROC is based, it is through that if clinicians work collaboratively with consumers with these principles then the consumer will be reach their recovery.

Recovery Oriented Care Principles.

The principles of ROC were developed by SAMSHA (Pir, 2009). In order to understand ROC to date various studies throughout the country and across disciplines are developing models on how ROC approach can be used in offering services to consumers. The states of Ohio and Wisconsin is deemed in the literature as states that were running research to understand how ROC works and what is necessary to for consumers to be able to function back into society. The states did both qualitative and quantitative studies that have helped serve as the beginning stage for the development of ROC principles that was later fully developed by SAMSHA (Pir, 2009).

Ohio and Wisconsin Study

Between the years of 1996 – 1999 the state of Ohio Mental Health Department did a study in 22 of their 88 counties interviewing 890 consumers that utilize their services on how can they best be served and what worked for them as they go through the process of recovery (Frese, Stanley, Kress, & Vogel-Scibilia, 2001). According to the consumer the best way to use ROC is to work collaboratively with consumers. Additionally the consumer needed to feel supported by their providers and those that they have interactions with in order to be on a path to recovery (Frese, Stanley, Kress, & Vogel-Scibilia, 2001). Additionally, language was a key to how communication happens between the consumer, providers, and society. Language can be used to challenge the

stigma and discrimination that comes along with mental illness (Spaniol, 1994). It was the groundwork in this study that has led us to where we currently are today in treating and continuing to develop policies and ways to practice ROC.

In 1994 -1996 a quantitative study was conducted in the states of Ohio and Georgia with 1,076 schizophrenia's surveys were administered to them and stored on the "Patient Outcomes Research Team" (PORT) through the Department of Veterans Affairs (VA) (Lehman & Steinwachs, 1998; Rosenheck & Steinwachs, 2000). The survey looked at areas of "demographics, four recovery orientation dimensions, client background, health status, and services used" (Resnick, Rosenheck, & Lehman, 2004). Multiple regression analysis was used to analyze the data of what the consumer with schizophrenia found most helpful in their path to recovery. The results indicated that there are four areas in which consumers find helpful in recovering "life satisfaction, hope and optimism, knowledge about mental illness and services, empowerment" (Resnick, Rosenheck, & Lehman, 2004).

In the search for what is helpful in treating the consumer, Wisconsin did a study with the Wisconsin recovery implementation task force team (Jacobson & Greenley, 2001). The team was comprised of "consumers, providers, advocates, and policy makers (Jacobson & Greenley, 2001)." Their task at the time was to make abstraction of the few principles more concrete. They looked at what they called external and internal factors of principles that make up for their recovery. The internal factors look at experiences, behaviors, and process of change for a person on the path to recovery. The external factors are the things at the larger social context such as policies, events, movements, and circumstance that foster recovery (Jacobson & Greenley, 2001).

Internal Factors

Hope. It is the beginning stage of recovery for a consumer; it is what gives the consumer the energy to fight to overcome the illness. According to Deegan (1988) it is the individual's perspective on the illness, by having hope; the consumer is able to believe that opportunities await them. Hope is being able to understand that there is a chance for the consumer to be able to have relief from the illness. Hope is the strength base component, it allows for consumers to look at their strengths rather than their limitations, being future oriented, not allow past experience to determine their outcomes, being able to rejoice with small progress, and having an optimistic outlook.

Hope is a spiritual process as well as consumers believes can be viewed as grace, grace according to a consumer is "that each person who is struggling with a mental illness is allowed grace and everyone view grace differently. There is spiritual grace, which is having the belief in a higher power, whether it's God or connection with nature and then for those who do not believe in grace. Hope can be manifested through the work of art or philosophical beliefs" (Deegan, 1988; Jacobson & Greenley, 2001).

Healing. When thinking of healing in recovery it does not mean that the consumer will wake up and no longer have a mental illness. What it does mean is that the consumer is participating in activities and is able to function and not allow for the illness to overcome them. According to Estroff (1989) the process of healing take place in two ways; first, focusing on the "self and having control." The first part of the process is the person with mental illness focuses on the "self". Individuals with mental illness often forget who they are and allow for the illness to consume their life. Part of developing the self is working on issues of "self esteem and self respect" this allows for

the consumer to not focus on the stigma that society places on them or that they place on themselves, but they are able to connect to who they are (Jacobson & Greenley, 2001).

The second part of the process of healing is being able to control the symptoms; this could mean medication or monitoring triggers for the symptoms (Jacobson & Greenley, 2001), which can be caused by stress. A way to reduce stress is by having self care (Copeland, 1997; Crowley, 2000). Additionally, control means to be able to know who is in control of the illness; the consumer wants to be in control of their lives.

Empowerment. According to Spaniol, Koehler, & Hutchinson (1994), one of the goals of ROC is to have consumers take accountability for their lives; which can fall into both the internal and external factors, as well. In order for that to happen they need empowerment, which happens in threefold. First, act liberated. In order for that to take place the consumer must be aware of their condition, have “self-confidence,” and have decision-making skills. Second, is to have “courage” being able to step outside of their comfort zone and voice their opinions, and “take risk.”

Connection. Part of ROC is that the consumer does not feel alone in their illness but is aware of others that struggle as they do. By being able to connect with others they are able to re-attach themselves with society. By doing so, the consumer is finding out what contribution do they make to the community that they are involved in, as well as, the various relationships they are in both within and outside of their families? According to Curtis (2000), one of the most powerful connections for consumers that apply ROC in their lives is being able to mentor or advocate for someone else that is starting their recovery process. This means that the consumer is able to share their process of how they were able to recover by doing so, they are able to validate themselves and others.

External Factors

Human rights. The process of recovery for a consumer does not happen by the consumer's change in how they view themselves, but by the treatment and acceptance of the larger society. Human rights in ROC are consumers being able to be treated equally in society as well as not being dehumanized by those that society deem normal. It is being able to give consumers the opportunity to have their basic needs met (shelter, food, safety, and security) as well as protecting them from maltreatment in the system (Jacobson & Greenley, 2001). Additionally, human rights mean that the consumer is treated with respect and receive voluntary treatment. Human rights lead to development of policies for the consumer's treatment.

A positive culture for healing. This external factor deals with the clinicians that work with the consumer. The clinician has to believe in the skills that they are trained in and know that they can help to empower the consumer. They have to be able to look beyond the consumer diagnoses, socio-economic status, and be flexible in the skills they use for treating the consumer." For example, the clinicians cannot stick to a strict treatment plan but be willing to work collaboratively and have flexibility with the consumer in recovering.

Ten principles of recovery oriented care approach

Recovery oriented Care encompasses ten key principles to help the client/consumer move toward recovery. These principles attempt to provide consumers with hope, responsibility, empowerment, respect, peer support, a strength-based perspective, a non-linear approach, and individualized and self-centered, self-directed and holistic care. According to Borg & Kristiansen (2004), when utilized, these principles

represent a collaborative way of working between consumers and clinicians in which consumers are actively involved in their own recovery and professionals support and engage the consumer's capacity towards recovery.

Self-Direction

Clients or the consumers take the lead over what direction they choose to take with their recovery efforts. This approach gives them maximum autonomy. When consumers take the lead in their life or personal journey, they are able to set goals that fit their particular lifestyle (Goldstein, 2001; USDHHS, n.d).

Individualized and Person-Centered Change

ROC is personalized based on individuals' own strengths and the way they can cope with change. Therefore, there is no one way for persons to achieve their goals, but different paths and directions they can take to obtain their goals. The journey individuals may take is based on the needs they have to create a treatment plan toward a well-balanced life (Mitchell, 2001; USDHHS, n.d).

Empowerment

Empowerment is a key element in ROC because it places consumers in charge of their own destiny. They are given choices on the direction they want to take toward changing their lifestyle. Consumers are encouraged to converse with other peers, their psychiatrists, and the mental health services staff, about what they want to achieve. Consumers learn to utilize resources that are made available to them in order to help them attain their goals. Therefore, they become the central part of their own future by taking control of their lives. Consumers develop greater awareness of their situation and implement changes in the way they once functioned (Declan, 2005; USDHHS, n.d).

Holistic

A major component of ROC is to address everything about the individual's existence. This will encompass the person's mind, spirituality, and the environment. The holistic component of the model addresses shelter, income or finances, employment, learning new skills, enhancing education, and proper healthcare. The holistic approach also includes the community in which the person resides, family members, and a good support system (USDHHS, n.d).

Non-Linear

ROC is not a step-by-step process in the consumer's life; therefore, it is very circular in nature. As the person grows, the process toward change also grows with the individual. RM is an ongoing continuum of both growth and setbacks. The consumer learns through experiences of both failure and success, all the while embracing a positive structure toward recovery (USDHHS, n.d.).

Strength Based

An important concept in ROC is to build on the strengths that the individual already possesses. These strengths can be identified as the person's self-worth, values, and various talents. In addition, RM incorporates support from those who exist in the consumer's life such as caregivers, friends and family, and even employers. In order to build the strengths based approach, the consumer must build relationships of trust through interaction with others (USDHHS, n.d).

Peer Support

Peer support is a vital component of ROC because others who have been diagnosed with a mental disorder can share their experience. The support of peers can be

encouraging to the consumer because they can identify with them and share their successes. Peer support can facilitate a sense of belonging instead of feeling like an outcast. The support of others like themselves creates a sense of hope. Learning how to socialize within the community is another benefit of having peers. Along with the skills and experiences peers can offer, they are also instrumental in sharing coping strategies to help the consumer solve problems (Patton, 2006; USDHHS, n.d).

Respect

ROC is a system that implements respect for consumers by accepting them as human beings, honoring their rights, and not discriminating against them because of their mental illness. When the consumer's rights are being observed and respect is given they are able to begin functioning in the community without the stigma of their diagnoses hindering them because they begin to believe in themselves (Sells, Stayner & Davidson, 2004; USDHHS, n.d).

Responsibility

Consumers are in control of their wants, their needs, and their own goals therefore; they become responsible for the steps they take toward their recovery. In some instances the consumer may take backward steps, however, they have the responsibility to get back on track to move forward. Furthermore, ROC helps consumers take responsibility when it comes to such matters as their roles in employment, education, and independent medication management (P. Huff, personal communication, 2010; USDHHS, n.d).

Hope

ROC is centered on giving people hope not only in what they can accomplish, but also in their willingness to achieve success in their life. Hope may start at different levels, but it gradually grows within the individual as the person gains determination to move forward to achieve goals. When a person begins to have hope they begin to come alive with the strength to survive and overcome obstacles. RM encourages the consumer to not be deterred by barriers or hindrances, but to believe and hold on to the power they have within themselves (P. Huff, personal communication, 2010; Patton, 2006; USDHHS, n.d).

Application of Recovery Oriented Care in Marital and the Family Therapy

The work of ROC in the field of Marital and the Family Therapy (MFT) is still in its infancy phase. In searching the family literature there is one article that was recently published in July 2012, in the journal of Marriage and the Family Therapy, on how ROC can be applied to the work of MFT's. The principles of ROC such as hope, empowerment, self-direction, and respect have already been applied to MFT's work, but the mechanism of how the principles are used is different in how they create the process of change or recovery for the consumer (Lambert & Ogles, 2004). However, there has to be some ways in which there are similarities between ROC principles and MFT's work (McFarlane, Dixon, Lukens, & Lucksted, 2002).

Ways in which to better serve a particular population are always examined by professionals and researchers. The development of theory, models and approaches, is a way that one can better learn to serve individuals. In the field of Marriage and Family Therapy (MFT) there is an ongoing search for how one can best serve their clients and

the families they work with. ROC is a way in which MFT's can use to conceptualize how to work with mentally ill consumers and their families (Gehart, 2012). The approach symbolizes the way in which MFT's worked in the past, which is not to focus on diagnoses, rather how can the therapist help the family unit adjust and cope with the symptoms they are experiencing in the family.

MFT theories and ROC approach are similar in that they conceptualize cases from postmodern theories, where they see the consumer as the experts in their own lives and they should be included in how they are treated (Cohen et al, 2012). For example Solution Focus Brief Therapy (SFBT) and ROC are similar because they are both strength-based approaches that view the client/consumer as the expert in their care (Nichols & Schwartz, 2008; Dejong & Kim-Berg, 2008; Cohen et al, 2012). In order for a person to use ROC they must be able to be hopeful for the consumer that they can live their life to their own full potential (Farkas, Gangne, Anthony, & Chamberlin, 2005).

Gehart (2012), shares some of the reactions that MFT's in the state of California had when they learned about the ROC approach being used with their clinicians. She proposes a model that could discuss reactions on how to help MFTs adjust to ROC as well as how they can adjust to the application of ROC. In a sense Gehart is normalizing for MFT that the way they react is expected when they are now asked to use ROC in their work with consumers. Gehart (2012) makes it clear that not every MFT will react to ROC like what she proposes in the model process. This model has four phases: (1) horror, outrage, and righteous indignation phase. This is described when MFT's were introduced to the ROC program, their reaction was fear and anger as to how they should now work from an approach that they are not in total agreement with. This reaction occurred

because MFT's felt that they were being forced to use ROC and that they had to put away their traditional ways of working with consumers. The suggestion for this phase is that MFT's not fear the adjustment to ROC, rather they embrace it and apply the skills set that they already have to assist consumers in achieving their personal and therapy goals. (2) The overconfidence phase. MFT begins to have a realization that ROC closely fits with the theories in which they are working from. Therapist then becomes confident in their work and when they speak of ROC they use phrases such as "I already do that in my session or we've been doing that for years" (Gehart, 2012). It is hard for one to say there an expert in ROC because it is still in its infancy phase. (3) The integration and balance phase. This phase in Gehart model discusses ways to adjust to ROC, she suggests that MFT's take the skills set that they have and modify it so that they can incorporate ROC ideas, as well as, the principles to their work. (4) The creative phase. In this phase MFT's are encouraged to become creative in the ways in which they incorporate the principles of ROC in their work. This is an exhilarating, and exploratory phase. This phase allows for administrators, researchers, program developers, and therapists to use their imagination and be innovative in how they apply the principles to their work. ROC leaves room for one to adjust the approach as to how they best work (Gehart, 2012).

Supervision and Recovery Oriented Care Approach

Clinicians working in the mental health field already have a number of comprehensive approaches as to how they work with and treat underserved and unserved population. However, a consistent flow of how the Recovery Oriented Care (ROC) approach is used in supervision has not yet been formulized. The formalization of the use of ROC in supervision may impact the maintenance and or solution of the problem the

intern may have in treating a consumer. In order to understand ROC in supervision one must explore the meaning of the 10 principles and its application with the severely mentally ill (SMI) population. SMI can be defined “as a group of individuals who have a psychiatric disorder that results in their ability to function in their daily care” (Ruggeri, Leese, Thornicroft, Bisoffi, Tansella, 2000).

The use of ROC principles in clinical work during supervision represents a shift in thinking from traditional mental health services in that it adopts a ‘whatever it takes’ motto. This means that clinicians may find themselves providing therapy in multiple situations outside of an office setting. The ‘whatever it takes’ motto also means that treatment may include much more consumer advocacy that has traditionally been employed by clinicians. For example, a clinician may meet a consumer at their home in order to provide services. In order to embody this ‘whatever it takes’ motto/attitude, it has been noted that clinicians should adopt a less illness-based approach. This would require a new understanding of severe mental illness, an understanding that is outside of the typical picture presented by diagnostic criteria. It would also require clinicians to be more open-minded about what actually helps and/or hurts the process of recovery (Sells, Stayner, Davidson, 2004; Davidson & White, 2007).

As one might expect, the shift from traditional mental health services to ROC requires applied training and oversight. In fact, there has even been a suggestion that becoming a professional who works from the ROC perspective includes a reorientation and redefinition of what it means to be a “professional” (Avieneri, Davis, Loewy, Read & Wexler, 2010; Borg & Kristiansen, 2004). Traditionally, clinical supervisors have

provided the task of orienting students and interns in ways –traditional and non-traditional – of working with clients/consumers.

In order to understand the needs supervisors have in using the ROC principles in their supervision, a search of the supervisor literature was conducted to have an awareness of the process of supervision. Although the study on the needs of supervisors using ROC principles is not geared only towards AAMFT supervisors, but those that are approved supervisors by the Board of Behavioral Science (BBS), a thorough investigation of the literature for information on American Association of Marriage Family Therapy (AAMFT) supervision was searched to help conceptualize ways in which supervisors are expected to work in supervision with their intern, as an AAMFT supervisor; not only the ways in which they work but if there is any literature on using ROC principles. A review of the literature both within the AAMFT supervision and other discipline literature is limited on models that describe ways in which ROC principles can be utilized in supervision.

Supervision

The term supervision emerged from the work of Sigmund Freud; he used the Latin word supervidere meaning a “superior view” to help with his concept of how to teach psychotherapy beyond the classroom (Carroll, 1995). The idea of supervision is not new; it is often referred to as “professional supervision, supervision, or clinical supervision” depending on which field it is being used in (Jones, 1998). Clinical supervision is the opportunity for an intern to have an ongoing learning process outside of the classroom (Itzhaky & Chopra, 2005). It assists in the application of the material that is learned in the classroom; engage the clinician in exploring the therapeutic relationship

as well developing their therapeutic skills (Greben, 1991; Itzhaky & Stren, 1999; Watkins, 1996; Rich, 1993). According to Falender & Shafranske (2004), clinical supervision is defined as:

“A distinct professional activity in which education and training aimed at developing science- informed practices are facilitated through a collaborative interpersonal process. It involves observation, evaluation, feedback, facilitation of intern self-assessment, and acquisition of knowledge and skills by instruction, modeling, and mutual problem solving. Building on the recognition of the strengths and talents of the intern, supervision encourages self-efficacy. Supervision ensures that clinical (supervision) is conducted in a competent manner in which ethical standards, legal prescriptions, and professional practices are used to promote and protect the welfare of the client, the profession, and society at large (p.3).”

Clinical supervision is one of the most comprehensive approaches for fostering and furthering the development of the intern’s professional and clinical skills (Bernard & Goodyear, 2004). The process of supervision has a multidimensional approach (Watkins, 1999) that focuses on the technical and personal process of being a clinician (Aponte & Carlsen, 2009). Supervision assists in the conceptualization of helping interns to further develop theories and interventions, caring for the well being of the client, and take into consideration issues of gender and socio-cultural (Lawson, Hein, & Stuart, 2009). The process of supervision is important because it helps in the facilitation of training and enhancing the development of the intern during training to be effective clinicians (Aponte & Carlsen, 2009; Crocket et al, 2007). Aponte and Carlsen (2009), state that supervision assists in identifying and exploring clinician issues in a case, developing hypothesis of a case, and helping the intern to utilize appropriate clinical intervention for the maximization of therapy. According to Green and Dekkers (2010), supervisors play an

important role in the growth of the clinical, social, professional, and training development of the intern.

Supervision in general is a broad terminology that is used in many fields such as nursing, education, social work, psychology, and behavioral health (Crocket et al, 2007). Although the term is used in various professions there is commonality in the meaning of supervision in the literature (Jones, 1998; Jones, 2006). In an effort to give the reader a basis of supervision this literature review focuses on the behavioral health field, particularly the field of Marital and Family Therapy (MFT). In the field of MFT, supervision is defined as:

“A continuous relationship focused in therapist practice setting and their specific development of competency as they gain radical experiences” (Liddle & Saba, 1986). That includes the following key elements: “1) an experienced therapist, 2) safeguarding the welfare of clients by, 3) monitoring a less experienced therapist performance, 4) with real clients in clinical setting, 5) with the intent to change the therapist behavior to resemble that of an exemplar therapist” (Mead, 1990, p.4).”

History of Clinical Supervision

In exploring the literature the notion of supervision can be dated back before the 1900's. During this time, clinical practices were administrated by boards, associations, state legislation, and charities. In the early 1900's the development of the notion of supervision began (Ronnestad & Skovholt, 2003). Schools were being developed to train clinicians as well as supervisors on how to work with clients. Those that taught supervision took the idea of “apprenticeship” (Haynes, Corey, & Moulton, 2003; Caligor, 1984). Supervision followed this process in the beginning where student would observe an individual that has more knowledgeable base in the area of psychotherapy, the individual would then teach the student on how to apply the necessary skill set for

conducting therapy (Falender & Shafranske, 2004, p. 9). In 1935 the concept of supervision began to play a major role into how clinicians should work, supervisors used Freud theory as a model for supervision (Caligor, 1984).

Freud followed the “apprenticeship” idea and psychoanalytic orientation when developing the idea of supervision. Freud was interested in how countertransference would disrupt the clinical process (Freud, 1964; Aponte & Carlsen, 2009). He believed that personal beliefs and values would influence the way in which clinicians work (Caligor, 1984). Freud held the first supervision group in Vienna (Jones, 1998). He took a group of clinicians and gave them instructions for cases, personal analyses, and discussed similar cases to assist in the conceptualization of how countertransference played a role in supervision (Aponte & Carlsen, 2009). Based on the experiences that these clinicians shared, Freud later developed a psychoanalytic model of supervision (Mearns, 1993; Jones, 1998). Prior to the Freud psychoanalytic model of supervision, supervision was viewed as an informal process (Carroll, 2007).

In the 1950’s, supervisors still used the psychotherapy model of supervision and the manifestation of the role of supervisor being the teacher and the intern as the learner began to become more apparent (Jones, 1998). As supervision continues to be used across disciplines, the field of MFT began to observe how supervision plays a role in working with families (Aponte & Carlsen, 2009). In 1971 supervision was introduced to the field of MFT (Lee, Nichols, Nichols, & Odom, 2004). When supervision was first used in MFT, supervisors followed the psychoanalytic model that Freud developed (Todd & Storm, 1997). As supervision began to be developed into the field, supervisors were chosen based on the first set of MFT’s that graduated (Todd & Storm, 1997). The field

then began exploring how the use of system plays a role in supervision. Bowen (1972) explored how supervisors can use the notion of differentiation in therapy to assist intern in conceptualizing their work with family. As the field is evolving the use of various system models help in understanding how supervisors supervise their intern. In the 1980's a plethora of models were developed in the field of MFT on how to work in supervision. For example intergenerational model that was influenced by the work of Bowen, symbolic-experiential model that was influenced by Whitaker & Keith, and structural model influenced by the work of Minuchin and Fishman, Haley, and Madanes (Betchen, 1995).

Purpose of Supervision

The ultimate purpose of supervision is to assist interns in being more effective in their work with clients (Aponte & Carlsen, 2009). Supervision helps the intern to move from bookwork to clinical work (Aponte & Winter, 2000). Supervision is utilized to help the intern identify, and develop the knowledge and skills to be able to practice effectively (Falender & Shafranske, 2004). Supervision assists the interns to engage in a process that helps shape their confidence and skills in the therapeutic process that is needed in order to cope with a wide range of diagnoses (Itzhaky & Chopra, 2005). During supervision the supervisor discusses the dyad between the intern and client and how the intern can work effectively to best serve the client (Frawley-O'Dea & Sarnat, 2001). Supervision is seen as a tool for obtaining further knowledge beyond the classroom (Diwan, Berger, & Ivy, 1996; Gleeson, 1992). Additionally, it helps to create structure and stability for how an intern can do their work (Giddings et al, 2008).

The process of supervision is one that is isomorphic (Holloway & Dunlap, 1990) it goes beyond enhancing the intern knowledge. Supervision models for the intern what it means to be in a hierarchical position (Holloway & Wolleat, 1994). Meaning, the intern is able to conceptualize how being in a one-down position feels and is able to understand how the client views their role as the therapist. As the intern looks to the supervisor for guidance the supervisor helps to draw knowledge out of the intern and facilitate in applying the knowledge to cases (Holloway & Wolleat, 1994; Falender & Shafranske, 2004). During the supervision process professional skills are developed. Interns learn how to interact by developing an effective supervision relationship where the supervisor is able to evaluate and monitor the performance and competencies of intern (Falender & Shafranske, 2004). Supervision provides the framework and structure from which interns are able to articulate cases (Holloway & Wolleat, 1994). Supervision helps shape the way interns will practice in the future. Supervision is an important piece of the educational and clinical training of interns as they learn to work with clients and professionally.

In the field of MFT the purpose of supervision is to further enhance the development of theories, interventions, and clinical skills (Everett, 1980; Nichols & Lee, 1999). The process of supervision is key to the development of clinicians (Bridges, 2005). During supervision, one learns the practical ways of how to conceptualize cases and have an awareness of them as a clinician (Gilbert & Evans 2000). Clinical supervision is one of the most constructive ways in which interns can learn the practical skills and professionalism that is needed to work with clients (Bernard & Goodyear, 2004).

Supervisors

According to Everett (1980), Nichols & Lee (1999), supervisors are responsible for conveying theoretical knowledge and the necessary skills for clinical practice. The role of the Supervisor is crucial to the learning of how the intern will comprehend how to work with clients beyond book knowledge (Arieti, 1974; Searles, 1965). Supervisors help to shape and strength the knowledge that the intern will need in order to be an effective therapist (Itzhaky & Chopra, 2005). Supervisors are able to convey this based on the supervision model or approach that they utilize in exploring how the intern functions with their client. The supervisor guides the intern in how to develop goals for their clients, note progress of the client and enhance the learning of the intern (Davidson & Strauss, 1992). The supervisor is the key to learning and professional development (Holloway & Wolleat, 1994). Supervisors are there to foster the growth and development of the interns, as well as, evaluate their progress as a clinician (Bernard, 2005). Supervisors are placed in a major role in which they are able to influence the clinical, social, and professional development of interns (Greens and Dekkers, 2010).

Supervisor's qualification. Most supervisors fall under the BBS supervisors; these are the requirements. In general, supervisors are required to be a licensed counselor. It is expected that they have a minimum of 5 years experience in counseling, with at least two of those years being under supervision. All supervisors must have completed a graduate-level course in counseling. Ideally all supervisors will have provided boards with a statement of philosophy, orientation and experience in supervision. The BBS defines the requirement for all mental health supervisors in detail. Although this program is developed from a needs assessment of all fields of mental health, this will only address

the BBS stated requirements of supervisors for Licenses Marriage and Family Therapists (LMFT).

According to the BBS to become a mental health supervisor there are three main requirements they must first meet. The first is that all supervisors must have a valid California license for at least two years before they begin to supervise. The second is that all supervisors must complete 6-hour training on supervision within two years before supervision, and every renewal period after that. Lastly all LMFT supervisors must have practiced psychotherapy or directly supervised trainees, interns, or associate clinical social workers that performed psychotherapy in two of the five years before they conduct supervision. The AAMFT has similar requirements.

AAMFT supervisors must be in training for a minimum of two years with an AAMFT approved supervisor with a minimum of 36 hours. They must also complete a 30 contact hour course in marriage and family therapy supervision. This course must include both interactional and didactic methods. AAMFT supervisors must conduct 180 hours of supervision to MFTs or MFT trainees, and of those they must have at least supervised 2 of those trainees for at least nine months. All AAMFT supervisors must have completed two years of clinical experience after obtaining their MFT license.

Responsibility of supervisor. The main responsibility of a Supervisor is to create a functioning relationship between the intern and themselves. Students who feel that their supervisor is knowledgeable in the field, as well as have a good relationship are more likely to succeed, and be satisfied with their training. Students identify that supervisors that they have close cooperation, conduct regular supervisions contribute to a better learning environment (Franke 2011). The supervisor organizes supervisions, with the

main focus being support for the student in their learning process. It is expected that Supervisors are knowledgeable enough in their field to conduct supervision (Franke & Arvidsson 2011). During the supervision the supervisor is responsible to get an accurate account of the intern's interactions with a client to offer assistance with their learning of becoming a counselor.

The supervisor is responsible for getting an account of what happened with the client. The supervisor then helps the supervisee identify their thoughts and feelings they have regarding their client for transference issues the intern may have with the client. It is then important for the supervisor to reflect on the dynamics and underlying issues of the session, to assist in identifying the way the client views their world and situation. This will allow for the supervisor to assist the intern in identifying future treatment and interventions (Omand 2010).

Process of supervision. Supervision is the process in which education and training is used to create a scientific practice that is created through a collaborative process. It entails observation feedback, evaluation, self-assessment, and problem solving (Falender & Shafranske 2004). It consists of the supervisor and intern meeting on a regular basis to explore clinical and professional topics to assist with the professional development of the intern. The supervisor's main function is to primarily provide education to the intern to maintain the professional relationship (Holloway & Wolleat 1994). The supervisor is responsible to give guidance on clients and to ensure that the intern is competent in safe practice. They also at times can be responsible for the selection of therapeutic intervention (Jones 1998). The relationship between supervisor and intern entails a bond, goal planning, and agreement on tasks. A good relationship

allows for the pair to work through conflicts more easily (Falender & Shafranske 2004). The supervisor is the facilitator and guide for the intern to choose and develop their own practices (Jones 1998).

An important component of supervision is to educate the intern on the need to be aware that their personal values and beliefs are infused in the theories and techniques they will use. Supervision is also subject to personal influence in which supervisors as well must be aware of their own beliefs, values and their effect on the process of supervision (Falender & Shafranske 2004). Supervision relies on social interaction to provide knowledge and professional skills as well as modeling the dynamics of a one to one relationship. It allows for the intern to obtain the skills and ethics of the field (Holloway & Wolleat 1994). A major focus of supervision is ensuring that trainees receive clinical consultation that is conducted following ethical standards, and professional practices to protect the client, profession and society (Falender & Shafranske 2004). Supervision is an ongoing process in which individuals bring their unique interpersonal, values, and expectations of supervision (Holloway & Wolleat 1994).

Supervisor and supervisee relationship. Experts in the field of clinical supervision assert that the supervisor-intern relationship provides the structure and framework for learning how to apply knowledge, theory and clinical procedures to solve human problems (Falender & Shafranske, 2004) as well as support, challenge, and stimulate the training of the intern (Grant & Schofield, 2007). The focus of clinical supervision is on “the intern’s clinical interventions that directly affect the client, as well as, those behaviors related to the intern’s personal and professional functioning” (Bradley & Kottler, 2001, p. 5).

According to Cohen, Abraham, Burk and Stein (2012) the relationship between supervisors and interns are crucial in the understanding of ROC. The transformation is new and although intern may have the book knowledge of ROC they are lacking the application aspect. This is where supervisor play a role in helping them to understand the principles. Having a supervisory relationship where supervisors show empathy and open communication to the intern can enhance the intern's conceptualization of ROC.

Utilization of Evaluations in Supervision

In supervision the most used form of evaluations are summative and formative evaluations (Falender & Shafranske, 2004). Typically evaluation is done using a qualitative or quantitative methodology. These methods are used to measure the level of competencies in intern (Ladany, 2002). The intern then measures the process of supervision and the supervisory relationship (Cone, 2001). According to Worthen and Isakson (2000) intern also evaluate the whether the supervisor is one that is suitable for them as a intern, help them with the conceptualization of cases, helps with developing interventions for clients, respect the intern culture and does not hierarchical power to intimidate the intern.

Part of the supervision process is providing for supervisors as well as intern (Falender & Shafranske, 2004). This is a key component in helping the supervisor to understand what he/she can do to improve the supervision. Furthermore it helps the supervisor to know areas of strength and weakness as well as areas which further growth needs to be developed in the supervision process (Gross, 2005). Evaluation is an essential piece of supervision; supervisors are ethically responsible for evaluating interns performance and development across the field of behavioral health (Henderson, Cawyer,

Watkin, 1999). The use of evaluation in supervision can be used as tool for necessary changes that need to be incorporated for the development of the intern as well as strengthen the supervisor relationship (Ladany, 2004).

There are multiple forms of assessments that can utilize for the evaluation of supervision. There is the “Supervision Satisfaction Questionnaire” that was developed by Ladany, Hill, Corbett, & Nutt (1996), this assessment informs supervisors of areas in which there is less satisfaction. Also, the “Intern Perception of Supervision” that was developed by Olk and Freidlander (1992) to examines the level of certainty and uncertainty in supervision.

Filling the Recovery Oriented Care Supervision Gap

Despite the importance of the supervisor role, several disturbing facts are found in the supervision literature. The first of these is that little attention has been given to the ways in which supervisors develop competence (Bernard & Goodyear, 2009). Secondly, many supervisors practice without the benefit of education and training beyond those minimum qualifications required by the BBS (ASPPB Task Force on Supervision Guidelines, 1998, Bernard & Goodyear, 2009, Falendar & Shafranske, 2004, Scott, Ingram, Vitanza & Smith, 2000). Last but certainly not least, without further education and training, supervisors tend to rely on their personal experiences – as a intern with past supervisors, etc. – to guide their interaction with students and interns (Falender & Shafranske, 2004, Pearson, 2006). Coupling the newness of recovery-oriented care within mental health with the push to incorporate it into treatment, a major question arises from this literature. That is, how are supervisors training their students and interns to provide

this care? More specifically, what are the tools that supervisors are using to train their interns in the application of recovery-oriented principles with consumers?

To date, literature on the use of recovery-oriented care in mental health has focused primarily on treatment recipients (Borg, Kristiansen, 2004; Davidson, 2003; Jerrell, Cousins, Roberts, 2006). A thorough search of the behavioral sciences literature suggests that little attention has been given to the processes used by clinical supervisors who make use of a ROC perspective. Studies that attempt to illuminate general clinical supervision processes, however, appear to privilege a qualitative methodology (Ellis, 2010; Pearson, 2006) that allows for more description of these processes on the part of participants.

As previously mentioned, there are two other training programs that focus on introducing supervisors on terms used in ROC SAMSHA online training. Also the AAMFTCA focuses on informing supervisors on MHSA and ROC principles in supervision. The U-ROC supervisor-training program attempts to continue the tradition of these other programs in providing supervisors with ways of applying the principles of ROC in their supervision. The U-ROC program offers a unique contribution to this body of knowledge through its incorporation of information gathered through qualitative research with clinical supervisors in MHSA funded organizations. In addition, the U-ROC supervisor-training program will be run through a two-part evaluation process in the hope of securing feedback that will further inform the training program in this area

Program Development

A program is defined as an established set of activities that is developed to achieve a stated set of goals and objectives that has desired outcomes (Netting, Kettnner,

& McMurty, 2008; Issel, 2009; Girdano, 1986). Programs are developed to fit various culture, gender, and settings (Fink, 1995). Additionally, programs have different purposes, structures and organization, and treatment groups (Fink, 1995). In developing a program the developer has a philosophy in which their idea for a program came from and it is out of this philosophy that objectives and goals are established (Girdano, 1986; Timmerick, 2003). There are multiple models used to develop programs, e.g. the medical model, behavioral health models, social science models, and educational models (Sussman, 2001; Kettner, Moroney, & Martin, 2008; Issel, 2009; Rossi, Freeman, & Lipsey, 1999).

The steps to developing a training program includes and are not limited to understating the purpose of the program, the rational for developing the program by addressing the needs of that population, the theory of change, establishing clear goals and objectives, and a evaluation to examine whether the program is delivering its intended services (Knetter, Moroney, & Martin, 2008; Fink, 1995). A comprehensive program is one that is effective and efficient in service delivery (Girdano, 1986) when developing a program that is geared towards a particular population there are a series of steps the developer should follow to conceptualizing a clear outcome of their program (Kettner, Moroney, & Martin, 2008).

Purpose of a developed program

Programs are developed to address a problem for a particular population by developing activities that would lead to the implementation of interventions to address that problem (Rossi, Freeman, Lipsey, 1999; Healey & Zimmerman, 2010). When developing a program the developer should ask his/herself why are they developing this

specific intervention, what will happen to the population if one develops a service, what services will give the desired outcome, and how do I measure for outcomes and results (Kapp & Anderson, 2010; Kettner, Moroney, & Martin, 2008; Issel, 2009; Sussman, 2001)? Prior to the development of a program the developer has to do their research in order to understand the population for whom they will be developing interventions (Kettner, Moroney & Martin, 2008).

Rational/ Needs Assessment of a Program

The rationale of a program is the key component for planning and developing program (Carolina, 2009) it gives in detail why the program was developed. The rationale gives the foundation for the program (Timmerick, 2003). Having a rationale helps making decisions on steps to take in the development of a program as well as gives the guideline for talking with stakeholders (Timmerick, 2003; Carolina, 2009). In order for one to have a rationale prior needs assessment has to be conducted such as researching the target population (Healey & Zimmerman, 2010).

In developing a program one has to identify what is the problem and why this population will benefit from the service being provided (Sussman, 2001). As well as identify the specific population they are targeting. By doing so they are clearly defining the problem they see in the population. For example, the utilization of recovery oriented care principles in supervision. Now that a problem is identified, research is conducted to discover what has already been done to address this problem. For example after researchers conduct their research they find that there is a gap in the literature in the use of recovery oriented care principle in supervision. Next, a needs assessment is conducted (Kettner, Moroney, & Martin, 2008).

Needs assessments are developed to address the social problem that a population is having by investigating what those needs are (Rossi, Freeman, Lipsey, 1999) through a series of analysis (Kettner, Moroney, & Martin, 2008). The needs assessment is able to get the perception and interest of the population. This can be conducted by running focus groups or through the use of surveys (Sussman, 2001). In following the needs assessment from the Kettner, Moroney, and Martin (2008) book “*Designing and managing programs*” there are four different forms of needs assessment that developers use to explore the need of a community: first, normative need where the expert recommends these needs. Second, perceived needs where the population identify that they are in need of this particular services. Third, express need identified by those that are receiving the services. Fourth, relative needs where there is a comparison of needs based on geographical area resource where one may see that it works for this area and that this area lacks that need and may benefit from it. Need assessments help by identifying recommendations to support the development of intervention and fill the gap in services or issue that was not recognized prior to the assessment (Rossi, Freeman, & Lipsey, 1999; Royse, Thyer, Padgett, 2010).

Theory of Change in Program Development

In conceptualizing the problem that needs to be addressed in a population, theories are used to understand the etiology of the problem and the elements associated with it (Kettner, Moroney, & Martin, 2008). According to Sussman (2001), there are questions in which the developers such as the belief as to how will the program be conducted? How will the activities that are developed create the desired outcome (change) one is hoping for? The theory of change becomes ideas that are developed and

hypothesize that if A is done then B will happen (Sussman, 2001; Kettner, Moroney, & Martin, 2008). The theory of change looks at the variables in change occurring. There are two types of variables that are assessed; mediating variables help with the facilitation of outcomes and moderating variables that looks at the cause of the problem (Sussman, 2001). In developing a theory of change various models can be used in helping to facilitate in the theory of change. One such model is a logic model (Kettner, Moroney, & Martin, 2008) it helps in determining the theory to use (Savaya & Waysman, 2005). Additionally, the rationale behind the logic model is to track events that are occurring, identify resources, and correlate them to the needs, and help with the measurements.

Goals and Objectives of Program Development

In an effective program clear goals and objectives are established. Developing goals and objectives allows for the developers to have something to work from in order to have format for monitoring and measuring outcomes (Kettner, Moroney, & Martin, 2008). According to Issel, (2009) and Kettner, Moroney, & Martin (2008), goals and objectives are defined as goals give the direction for the program (Sheridan & Williams, 2011) and objectives specify what the program is trying to accomplish. The objective can be identified as the purpose of the program (Fink, 1995).

Program Evaluation

In developing an evaluation one needs to have a comprehensive understanding of the program for which they will develop an evaluation. This section of the paper focuses on the use of evaluation in programs. The idea of evaluation comes from the understanding that social service programs should have benefits (Berk & Rossi, 1999). The word evaluation can take on multiple meanings. According to Timmerick (2003) and

Rossi, Freeman, & Lipsey (1999), program evaluation is defined as “the use of process to systematically investigate the effectiveness of social interventions and determining the degree to which an objective of a program or procedure has been completed or met.”

Program evaluation has one major purpose and that is to give feedback to those that make major decisions in programs that will contribute to the betterment of service quality (Posavac & Carey, 2003, p.50).

According to Berk & Rossi (1999), program evaluation is an ongoing process that seeks to investigate how the program is designed, how the program is functioning, the impact of the program, and the analysis of program benefits. Evaluation examines the characteristics of a program as well as the advantages and disadvantages of a program (Fink, 1995). A good program evaluation includes the program design, evaluation question, methodological structure, data collection and analysis, and recommendations for implementations (Cronbach, 1982; Taylor, Gibbon, & Morris, 1987; Kapp & Anderson, 2010; Rossi, Freeman, & Lipsey, 1999; Posavac & Carey, 2003). When conducting a program evaluation there are 4 ways in which the evaluator can look at the process: 1). Is this going to make an impact? 2). Is what I am evaluating measurable? 3). Is the program worth funding? 4). Will the impact make a difference in the community (Girdano, 1986; Fink, 1995; Timmerick, 2010). In order to conceptualize the process of program evaluation, use of a specific form of evaluation is necessary.

Forms of evaluations. In general there are multiple forms of evaluation methodology. Issel (2009) Identify several major forms of evaluation: 1) Process evaluation, concentrates on the degree and quality of program implementation. 2) Effective evaluation answers the question; did the program make the impact it was meant

to? 3) Outcome evaluation looks at the immediate effect of the program. 4) Meta-evaluation examines previous evaluations that were conducted and combines it with new evaluation to conceptualize and determine the maximum effect of a program. 5) Summative evaluation is conducted at the end of a program to determine the impact of the program. This form of evaluation is often times referred to as impact evaluation. 6) Formative evaluation is utilized in the early form of a program that assesses the changes that needs to be made to improve the program. This form of evaluation may include parts of process evaluation. The use of formative evaluation will be utilized to evaluate the U-ROC supervision-training program.

Formative evaluation. Formative evaluation was chosen for the U-ROC evaluation to inform the developer what changes needs to be made in order to have an effective training program. It seeks to make changes as the program is being implemented as well as look at the effectiveness of the program (Timmerick, 2010). This form of evaluation identifies program appropriateness (Christoffel & Gallagher 2006) and it seeks to identify potential problems with the implementation of a program. Formative evaluation investigates the process of how the program is being implemented. By doing so evaluators ask questions such as are

1. Is the program being implemented as it was designed?
2. Do the participants understand the program's concepts?
3. What are the misconceptions about the program?
4. Are all program implementers implementing the program in the same way?
5. What aspects of the program do not seem to be working as well as were intended?

(Hosp, 2012)

Assessment of programs. The assessment phase of formative evaluation is used to do data collection from key informants and stakeholders (Hosp, 2012). According to Rossi, Freeman, and Lipsey (1999) the evaluator needs to have a comprehensive understanding of the development of the program, which they are evaluating. Evaluators have to do their research to understand what the program was designed to do and what are the expected outcomes are. This can be done by searching the literature or communicating with stakeholders (Timmerick, 2010). In so doing the evaluator is exploring the needs of the population, the goals of the program, and the expected outcomes. The assessment can be used to help the evaluator make decisions of the questions they need to formulate to understand the evaluation (Hosp, 2010).

Purpose evaluation. Having a purpose during an evaluation process assists the evaluator to focus and define what they are evaluating. The purpose of an evaluation is to help administrators determine how programs can be improved. It provides input as well as helps the evaluator conceptualize what stakeholders are seeking (Rossie, Freeman, & Lipsey, 1999). A formative evaluation is designed to monitor the appropriateness of a program and whether the program implemented is reaching the outcome it set forth. Formative evaluation serves the purpose of exploring gaps and expected outcome (Kealey, 2010).

Evaluation question. The evaluation question helps to identify the problem and it must be developed clearly. Typically, an evaluator works with the stakeholders to explore what they have in mind as far as their understanding of the problem and a hypothesis can be developed to help with the problem (Rossi, Freeman, & Lipsey, 1999). Also, the evaluation question helps the evaluator plan out their evaluation. The question of the

evaluation is based on a needs assessment, that is, what does the program need in order to be sufficient (Rossi, Freeman, & Lipsey, 1999)? Additionally, what is the theory of change in the program as well as the outcome?

Goals and Objectives in Evaluation

Goals and objectives are used for the evaluators to have something to work from in order to have a format for monitoring and measuring outcomes (Kettner, Moroney, & Martin, 2008). According to Issel, (2009) and Kettner, Moroney, and Martin (2008), goals are defined as giving the direction for the program (Sheridan & Williams, 2011) and objectives specify what the program is trying to accomplish. The objective can be identified as the purpose of the program (Fink, 1995). The goal of formative evaluation is to find ways of improving program and assurance of outcome goals (Patton, 2002).

CHAPTER FIVE

DEVELOPMENT OF THE UTILIZATION OF RECOVERY ORIENTED CARE CLINICAL SUPERVISOR TRAINING PROGRAM

Program Description

The Utilization of Recovery Oriented Care (U-ROC) clinical supervisor training program and evaluation, influenced by symbolic interactionism theory, is designed to train clinical supervisors on how to incorporate the 10 principles of ROC approach in their supervision process. The principles' attempt to provide consumers with hope, responsibility, empowerment, respect, peer support, a strength-based perspective, a non-linear approach, person-centered, self-directed and holistic care (Davidson et al, 2007). The principles were developed with a specific service delivery for the severely mentally ill population. The approach includes the collaboration of consumers and practitioners in the treatment plan. The training focus on providing supervisors with a concrete understanding of the individual principles and the essential tools and skills necessary for supervisors to apply ROC in their individual work and in their supervision process. The U-ROC training utilizes a formative evaluation based on three indicators: U-ROC pre-, post-test, U-ROC follow up, and self report survey. The purpose of using the formative evaluation is to inform the developer of methods to further improve the U-ROC training program and gain a sense of awareness on particular principles that may need further development in the training. The U-ROC training program is developed based on a needs assessment that was conducted using a qualitative methodology and analyzed by grounded theory. The tenets of the program are influenced by the themes that emerged

from the data. The program is geared towards assisting experienced and inexperienced supervisors on how they can further advance the knowledge of their supervisee's when incorporating ROC in supervision. Additionally, supervisors will learn different approaches to aid in the process of incorporating ROC in supervision. The purpose of the training program is to educate and provide supervisors with the necessary tools, knowledge, and skills to further train their supervisees on the use of ROC with their consumers. The training is intended to train supervisors on how to use specific approaches in their supervision.

Program layout

The training program was intended for a maximum of 20 supervisors per training that are interested in being trained or further increasing their knowledge on the 10 principles of ROC. The training utilized various forms of learning e.g. role-playing, metaphors, and vignettes, to help supervisors conceptualize the principles. An extensive power point presentation was developed to allow for visual aid of the training. Supervisors were provided with handouts from the power point in order to assist them in following along and taking notes.

The following is a layout of the 4 hour intensive U-ROC training program. The training incorporated interactive points in which participants were expected to discuss training content with each other. Pre- and post- tests were given prior to the training starting and after the training.

Orientation. Supervisors were greeted and asked to fill out a demographic sheet. The developer then welcomed supervisors. Participants were asked to take the U-ROC supervisor pre-test that lasted approximately twenty minutes. After the pre-test,

supervisors were asked to share with the group the particular population they serve at their clinical site and their experience they have with ROC.

Principles. For the first half of the training, 5 principles (self direction, individualized and self centered, responsibility, empowerment, and holistic) were discussed in detail, including the meaning of each. Throughout this portion of the training supervisors were given opportunities to share experiences they may have had with one of the principles or how their clinic may or may not be using the principals.

Break. A break was given. After the break, supervisors were asked, as a group, to process and discuss a clinical vignette and share how they would apply the first five principles in which they were now trained.

Principles. The next portion of the training was similar to that of the first half; however, with the focus on the last 5 principles (non-linear, strength-based, peer support, respect for the consumer, and hope). At the end of the discussion supervisors were divided into two groups to role-play. Half of the group played the role of the supervisee and the other half played supervisors. The supervisee group came up with a case to present and the supervisors focused on how they would use the 10 principles and “TIONS” approaches with this particular case. The developer guided the discussion to make sure supervisors used ROC language when talking with supervisees. At the Riverside location, time was given to allow supervisors to consider at least one immediate change that they would like to make in their supervision practice. The supervisors were notified that they would be asked to share this change with all the participants.

Evaluation. At the end of the training, the U-ROC supervisors' post-test was administered; this was a multiple-choice test. A survey was attached to the post-test that explored what particular approach and principles supervisors will continue to use after the training. The survey is used to explore program effectiveness as well as areas of program improvement. Supervisors were asked to participate in a follow up online, in which they would take another U-ROC test and survey to explore how they have been applying the principles and the concepts of the training in their supervision.

Theory of change

The process of change in regards to supervisors attending a training program that focuses on the implementation of ROC in supervision is linked to the theory of supervision models. If there is a commonality of how ROC is incorporated for some supervisors, then there is a likelihood that other supervisors could benefit from having a way in which to use the approach. Supervisors are expected to have knowledge and incorporate ROC principles in their supervision. Supervisors are expected to enhance the learning process of supervisees and if ROC is now being built into educational curriculums, then supervisors will have to indicate their ability to conceptualize what ROC is and how they can best assist their supervisee in understanding the mechanism of the approach and utilize it in their sessions with consumers.

CHAPTER SIX

METHODOLOGY

Development of the U-ROC Clinical Supervisor Training Program Methodology

The U-ROC clinical supervisor training program was developed out of a prior needs assessment by means of a qualitative methodology namely grounded theory inquiry. The writer will discuss the methodological process that was used to conduct the needs assessment for the development of the training program and the evaluation process.

According to Strauss & Corbin (1998), qualitative research approach is any form of research in which results are not yielded from a “statistical analysis or from any form of quantification” (pp.55). In qualitative research one is able to conceptualize how persons construct their “social world and reality” (Hesse-Biber, 2010) as well as deconstruct how individuals make meaning of their experiences (Denzin, Lincoln & Giardina, 2006). In a qualitative study the process of meaning is important, it is not one that can be measured or replicated (Daly, 2007). Qualitative method is exploratory (Creswell, 2003). It allows the researcher to take a particular population that has not yet been study and develop theories or ways in which to conceptualize how to work with the population. Additionally, it allows for the researcher to examine individuals in their own milieu (Denzin & Lincoln, 2008), have an understanding of their lives, intricate experiences, reactions, social movements, and cultural phenomena (Strauss & Corbin, 1998). Also, it allows for the researchers to gather data that they can learn from and be able to hypothesize meaning that individuals share in their particular term (Creswell, 2003; Denzin & Lincoln, 2003).

In grounded theory the researcher interviews participants to understand and acquire what their experiences are (Charmaz, 2006). Grounded theory answers the question of how the participants make meaning of their experiences. According to Glaser & Strauss (1967), grounded theory is supposed to help the researcher clarify for the population their experiences and find ways in which they can better understand the topic. Part of the process of grounded theory is that the researcher is constantly referring back to the data to create theory and “grounding” the theory into data collected, as opposed to theory being developed from “preexisting” data (Maxwell, 2005). The goal of grounded theory is to conceptualize what is occurring in a particular population that is not studied (Hunter et al, 2011). The theory leaves room for adjustments to various settings (Hunter et al, 2011). This fits the conceptualization of recovery oriented care principles being incorporated in supervision, it is an area that is not studied and it will allow researchers to develop theories and models that supervisors can utilize.

Grounded theory was used as a method to target clinical supervisors who work in MHSA funded organization within the state of CA for the needs assessment. As aforementioned, there is little research regarding how supervisors actually incorporate ROC into their training methodology. As such these supervisors face a need to develop appropriate techniques with little empirical information as a foundation. Content for this ROC supervisor training program was gathered from clinical supervisors who found themselves in similar circumstances and have begun to develop strategies for bringing the principles of recovery into supervision. The use of grounded theory goes back to the theoretical framework of symbolic interactionism where supervisors are able to elucidate

the techniques that are used by clinical supervisors that are utilizing ROC in their supervision with their supervisees.

Sample Selection

In grounded theory sampling is used to assist in developing theory, it is not used to characterize the general population (Charmaz, 2006). When deciding on the sample one must deliberate whether the sample is one that is fitting and appropriate for exploring what the researcher is investigating (Charmaz, 2006). Convenient samples of clinical supervisors were contacted from an online listing of public mental health clinics across the state of CA. The inclusionary criteria required participants to be conducting clinical supervision of Marriage and Family Therapy, Counseling and/or Social Work students or interns in a recovery-oriented treatment setting. These supervisors needed to have supervised at least one trainee/intern who worked with at least one severely mentally ill client within the last year. Supervisors who met these requirements were asked if they are interested in participating in a research study on ROC supervision. Those who were interested in participating received further information on the semi-structured interview process as well as anticipated time commitment and were asked to schedule a time to conduct the interview with study personnel.

The sample for the needs assessment consisted of 28 supervisors from across 6 counties in CA (Fresno, San Bernardino, Orange, Tulare, Riverside, and Los Angeles). The needs assessment was conducted from January 2012 to November 2012. Researchers conducted face to face qualitative interviews. The population comprised of 50% Caucasians, 15% Hispanics, 4% African American, and 30% identified as other. The age of participants ranged from 20 – 70 years old. Percentages for each age group follows:

31-40 years (30%), 41-50 years (30%), 51-60 years (26%), 20-30 years (4%), and 61-70 years (8%). The majority of the participants (96%) have a master's degree, and 4% have a doctorate. Sixty-nine percent are Licensed Marital and Family Therapists and 31% are Licensed Clinical Social Workers. Thirty-two percent of the population provides individual supervision, 8% provide group supervision, and 56% provide both individual and group supervision. For demographic questions see appendix C.

Data Collection

Data collecting grounded theory is based on the researcher's observations, interactions, and the materials that are congregated from participants (Charmaz, 2006). After that is completed, the researcher is able to analyze the data. In the needs assessment, the researcher contacted mental health agency directors within the state of California via telephone to gather clinical supervisor contact information. The researcher then contacted clinical supervisors via telephone to invite them to participate in the study. The researcher screened for inclusion criteria, provided information about the study during the telephone call and provided the supervisor with the option of participating in the study. Once individuals gave consent to be part of the study, the researcher arranged a time and place to conduct the interview. Refer to Appendix A for recruitment letter and informed consent.

Interview Process

In grounded theory, interviews are utilized to gather data. This process is used to explore the researcher's interest as well as gather the interviewee experience on the topic (Charmaz, 2006). In the interviewing process the questions are opened and the interviewer is there to guide the questions while allowing for flexibility in responses

(Charmaz, 2006). In order to understand the supervisor's use of ROC principles in supervision, an interview guide was used. This guide comprised of 25 opened questions focused on the ten core principles of recovery-oriented care: self-direction, individualized and person-centered, empowerment, responsibility, holistic, non-linear, strengths-based, peer-support, respect for the consumer and hope. During the interview, the researcher may have asked probing questions to clarify participant responses. Examples of questions are: When working with supervisees, what are the ways that you support consumers participating in the decisions that affect their own lives? During supervision, how do you assist your supervisees in developing and maintaining an outlook of the consumer as being resilient, that is, having multiple capacities, talents and coping skills? As a supervisor, what does the term "respect for the consumer" mean to you? Refer to Appendix B for questionnaire.

Data Entry and Storage

Interviews were audio-recorded and labeled with an assigned number, which were the sole means of identification of both recorded and transcribed versions of the interview. Interviews were conducted and transcribed by the researcher. Data was transcribed and saved to a secure location. **Analysis**

When using a grounded theory methodology there is a process that needs to be followed. The researcher is opened to what is happening in the participants' milieu so that he/she can capture the participant's experiences (Charmaz, 2006). During the analysis process, there is interaction between the researcher and the data (Strauss & Corbin, 1998; Osbourne,). After the data is collected the first thing accomplished is transcribing. Once the transcription is completed the researcher does his/her first level of

microanalysis called “open coding” (Strauss & Corbin, 1998). During this process the researcher is looking at what is happening in the data and asking questions such as: What is happening (Strauss & Corbin, 1998; Charmaz, 2006)? During that time they are doing analytic memos that reflect what they see in the data (Strauss & Corbin, 1998). The next step is “axial coding.” As themes are emerging from open coding, the understanding of how the theme relates begins to be clear. Additionally, axial coding adds depth and structure to what is happening in the data (Strauss & Corbin, 1998). Lastly, there is a refining process where the researcher integrates categories and explores how they are interrelated.

In the needs assessment twenty-eight interviews were conducted with clinical supervisors who are currently supervising clinicians within MHSA funded programs. Twenty-seven of that data were analyzed using grounded theory methodology. Open coding, axial coding, and select coding. Open coding starts off with reading the entire document. Throughout the reading of the document, patterns of how supervisors were using ROC in supervision begin to emerge. For example, they asked certain questions when looking at the various principles. The open question was directed by asking questions such as what does the supervisor mean by this and how many supervisors stated the same question for this particular principle. In the open coding the researcher began to use line by line coding in which the researcher looked for themes throughout the data in each line of the data. For example, themes such as parallel process, supervision is a dance, and using metaphor in supervision, continuously showed up in the data. Throughout the open coding it allowed the researcher to begin categorizing themes.

Axial coding is the next step in analyzing the data, helping the researcher to identify overlapping categories and common themes among supervisors. The researcher was able to categorize each principle based on an approach that emerged. The researcher named it the “TIONS” approach. The “TIONS” approach are interventions that supervisors stated they used in supervision in order to help them discuss ROC with their supervisee’s. The approach emerged out of the data as a way to help supervisors to categorize how to apply each principle in their supervision process. Table 1 describes the “TIONS” approach.

Table 1

“TIONS” Approach Description

Category Name	Description	Types
Questions	This is the way supervisors explore with supervisees what is happening between the supervisee and the consumer during the supervision process. Often times the questions that were used helped to develop a parallel process in supervision.	There are 3 different forms of questions a supervisor can ask: 1. Exploration questions 2. Structural questions 3. Survival questions
Reflections	Used as a way for the supervisor to train supervisee to walk in the path of the consumer or think about where the consumer may be coming from. The supervisor at times uses reflection as a way to teach supervisees how to interact with consumer.	
Discussions	Supervisors used this as a way to guide the conversation in supervision and give a structural way to interact with the supervisee. This approach helps the supervisor to discuss various topics in regards to a certain principle.	
Humanizations	This is a way to normalize the process of consumer behavior for the supervisee. It gives supervisors the opportunity to educate supervisee on re-humanizing consumers.	
Applications	This allows for supervisors to teach supervisee various ways to process their caseloads by applying different methods to the supervision process.	Supervisors use these methods in supervision: 1. Encouragement 2. Empowerment 3. Role playing 4. Metaphoric language 5. Educating supervisees on ways of going into community and finding resources.

Along with open and axial coding the researcher used analytic memo writing on the transcripts, with the goal of returning to the memos at a later point in the research process. Throughout this process, these memos and the data were continually referred to in an effort to ensure soundness between the identified data and the research question. The U-ROC supervision training programs was developed based on the themes that derived from the data that form the basic tenets of the programs. The program is developed based on the experiences that supervisors share on their utilization of ROC principles in supervision; along with the “TIONS” approach to help supervisors categorize how they discuss the principles in supervision.

Project Management Methodology

Development of Evaluation Design

The evaluation of the U-ROC training program was developed based on the principles of ROC. The evaluation served the purpose of assessing the effectiveness of the U-ROC supervisors training program; and used a mixed methodology. By means of using a pre-test, a posttest design, online follow up, and self-reported survey. This is a two-part evaluation. The first part of the evaluation is a pre- and post- multiple choice test and self reported survey. The second part of the evaluation will consist of a follow up test and a self-report survey based on the participant’s assessment of their own knowledge prior to the training and after the training. Additionally supervisors answered one open-ended question in regards to changes they have made since the training.

In the literature the use of mixed methodology is shown to be richer in data collection. The use of mixed methodology is common among program evaluation (Johnstone, 2004). According to Bledsoe and Graham (2005), the use of mixed

methodology informs program developers and evaluators how the program is functioning, by assessing the program qualitatively and quantitatively. The utilization of mixed methods in program evaluation is used to strengthen and explore limitations and biases of one method. Additionally, in data collection it ensures breadth and depth of information, as well, to strengthen the validity of the findings (Hanson, Creswell, Clark, Petska, & Creswell, 2005).

For the purpose of evaluating a program for clinical supervisors on the use of ROC principles, I utilized the formative evaluation. The use of formative evaluation was used to help in assisting the developer to understand what changes need to be made in order for supervisors to best comprehend the program. Formative evaluation will identify the appropriateness of the program. At the beginning stage of trying to conceptualize the use of recovery oriented care principles in a supervision training program, I want to understand what type of impact the training is having on the trainees and how the training can be adjusted to be better implemented as it seeks to educate supervisors on how to utilize the principles in their supervision.

Goals and Objectives of a Training Program and Evaluation

The primary goal of the U-ROC clinical supervisors training program is to provide a training program that would further enhance the development and knowledge of supervisors in the utilization of ROC's 10 principles in supervision. Supervisors typically follow various supervision models or therapeutic interventions. As new models and interventions are introduced to the field of behavioral health, supervisors are typically the ones that will help in the dissemination of information and application of the

model or intervention. The following objectives and activities provide measureable outcomes enhancing the development and knowledge of the supervisor.

Learning Objective 1: By the end of the 4 hour ROC training, supervisors will be able to be:

1. Knowledgeable of the background of ROC and MHSA as indicated at time point 2 as well as show improvement in their knowledge in ROC prior to the training, indicated by a difference in scores on the pre- and post- test at time point 2.
2. Knowledgeable of the 10 principles and have at least one new way to apply the principles in supervision at time point 2 and time point 3.
3. Discuss how the principles apply to process of supervision at time point 2 and 3.
4. Show through role-play their ability to utilize ROC principles in supervision that will be indicated at time point 1.

It is the hope of this evaluator that the following occurred as a result of attendance at this training; supervisors will (1) demonstrate that they are aware of the different principles and its meaning (2) utilize the principles in their supervision (3) have a greater knowledge of the application of the principles by practicing and utilizing the various skills they learned from the training.

Following is a table summarizing the core concepts, activities, key indicators, methods used to collect the information, and sources of information used in the collection process. All paper and pencil measures used to collect information appear in Appendix C and D of this project.

Table 2

Evaluation Matrix

Core Concepts	Activities	Key Indicators	Methods	Sources
What are the major areas this evaluation addresses?	Training activities utilized to accomplish Core concepts	What can I observe or measure to generate evidence?	How will I collect the evidence?	From whom or where will I obtain this evidence
Enhancing the development and knowledge of supervisors use of ROC in supervision.	-4 hour training in ROC -One month online follow-up of how supervisor are utilizing the tools they learned in training.	-At the end of the training supervisors scores will increase on the posttest based on their knowledge of ROC -Did supervisors use the approaches and tools learnt at the training based on response from online survey	-Pre-test U-ROC multiple choice test and self-reported survey -Posttest U-ROC multiple choice test and self-reported survey -One month online post training U-ROC multiple choice test and self-reported survey	Training -Pre-test -Posttest -Self-report survey

Research Question

There are two research questions in the evaluation of the program; first the evaluator is exploring the knowledge of supervisors prior to and after the training. The evaluator is also exploring how supervisors have utilized ROC after the training.

- How effective is the U-ROC Supervisor training program in increasing supervisor's knowledge of the principles in Recovery Oriented care approach?
- How have the supervisors utilize ROC in their supervision since the training program?

Participants. The sample for the training program consisted of supervisors from MHSA-funded agencies. Supervisors were both experienced and inexperienced in the use of ROC principles. The inclusionary criteria required participants to be conducting clinical supervision for Marriage and Family Therapy, Counseling and/or Social Work students or interns in a ROC treatment setting. In addition to the aforementioned criteria supervisors needed to have supervised at least one trainee/intern who worked with at least one severely mentally ill client within the last year. There were 15 supervisors that participated in the training program. Participants came from two distinct offices with the Fresno and Riverside County.

The first U-ROC clinical supervisor-training program was conducted in March of 2013 in Fresno County the North County One Stop Mental Health Clinic in Visalia, CA. Seven supervisors attended this training. Fifty seven percent of supervisors provided supervision in the city of Fresno, 14.3% in the city of Visalia, and 28.6% in multiple cities such as Reedly, Pinedale, and Sanger. Fifty-six percent of the participants range

from ages 31-50. Twenty-nine percent of supervisors range from 51-70 years of age. Fourteen percent of the population ranges from 21-30 years of age. The population is broken down ethnically with 71.4% Caucasian and 28.6% Hispanics. Of the population 85.7% has a Master's degree and 14.3% has a Bachelor degree. Sixty-eight of the population are licensed Marriage and Family Therapist and 33.3% are licensed Clinical Social Workers. Thirty-three percent of the population supervised for 4 years, 33.3% supervised for 6 years, and 33.3% supervised for 9 years. Supervisors provide 33% individual supervision, 33.3% group supervision, and 33.3% both individual and group supervision. Seventy-one of agency funding comes from multiple funding sources. Twenty-eight percent of agency funding comes from MHSA funding sources. Services are provided to majority of adults in Fresno County. Fifty-two percent frequently provided serves to adults, 14.3% very frequently provided serves to adults, 14.3% frequently provided services to transitional age youth, and 57.1% rarely provided services to older adults. One hundred percent of services are provided to individuals with a low SES status. Agency in the county never saw those of the upper class and rarely (28.6%) provided services to those of the middle class. Forty-seven percent of the consumers serve at the various agencies in Fresno are Hispanic, occasionally supervisors reported that they serve Caucasians, and rarely (71.4%) provide services to African Americans. For demographic questions see appendix D

The second U-ROC clinical supervisor-training program was conducted in April of 2013 in Riverside County. The training was held at the Riverside County Department of Mental Health office at the county western regional office located in Riverside. The training consisted of 8 supervisors. Eighty-eight percent of supervisors provided

supervision in the city of Riverside, and 12.5% in city of San Jacinto. Seventy-five percent of the participants range from ages 41-70 and 25% range from 20-40 years of age. The population is broken down ethnically with 50% white, 12.5% Hispanics, 25% of other ethnicity, and 12.5% of multiple ethnicities. Of the population 85.7% has a Master's degree and 14.3% has a Doctoral degree. Fifty-seven percent of the population are licensed Clinical Social Workers, 14.3% are licensed Marriage and Family Therapist, 14.3% are licensed clinical psychologist, and 14.3% is licensed in other fields. The population was broken down equally at 16.7% for supervisors providing supervision ranging from 2-37 years. Seventy-five percent of supervisors are BBS approved supervisors and 25% are approved in multiple entities. Supervisors provide 57.1% individual supervision, and 42.9% provide both individual and group supervision. Eighty-eight percent of agency funding comes from multiple funding sources. Thirteen percent of agency funding comes from MHSA funding sources. Services are provided to majority of children (40%) and adults (20%) very frequently in Riverside County. One hundred percent of services are provided to those with a low SES status. Supervisors reported they frequently provided services to Caucasians (40%), and rarely to African Americans (100%). For demographic questions see appendix D

Measurements

The U-ROC multiple choice pretest was designed using ROC 10 principles with 2 self-reported survey questions. This test assesses the knowledge level of supervisors prior to the training programs. The test is used to test the effectiveness of the training program. It is anticipated that participants would score high in the application of ROC principles when taking the test. A U-ROC multiple choice post-test was designed using ROC's 10

principles with 5 self reported survey questions, to assess supervisors knowledge as a result of the training program, by means of the supervisor pretest, posttest, and self-report survey. It was anticipated that there would be a ceiling effect at the onset of the program. As evidence by, ceiling effect, at the needs assessment phase, supervisors reported they were sure they knew how to utilize the 10 principles in supervision. With the results from the needs assessment it is projected that the supervisors would rate themselves high at the beginning and end of the program. In order to capture true program effectiveness, the idea is that a pre- and posttest would give supervisors an opportunity to take into consideration their knowledge prior to and after the training program. The U-ROC multiple choice posttest and self reported survey was administered at the end of the training to assess the knowledge level of the supervisor after the training programs. The test is used to assess the effectiveness of the training program.

The one month follow up online survey was developed using the U-ROC multiple choice questionnaire and self reported survey of how supervisors applied ROC since the training in their supervision. Questions were developed for the self reported survey on how supervisors are maintaining the use of ROC in supervision.

Data Collection

Data for this evaluation derives from the U-ROC Clinical Training program. This is a time series design. Data was collected at the beginning of the training and the conclusion of the one-day 4 hour training program. Data is collected to inform the evaluator what has worked in the training and ways to improve the program. The pretest, posttest, and one month follow-up online survey consisted of multiple choice questions that were developed simultaneously with the U-ROC Supervisor Training Program and

Evaluation; part of the package for each test that was administered at the different time points. Supervisors were asked to rate themselves on a self-reported survey of their level of knowledge of ROC.

The pretest is comprised of 12 multiple choice questions. The test was administered to assess supervisors understanding of each of the ROC principles. Additionally, supervisors were asked to rate themselves on a 5 point Likert Scale, (1= strongly disagree, 5=strongly agree) responding to two prompts, “I have a good understanding of this principle” and “I feel capable of assisting my supervisee in developing their understanding” in regard to the 10 ROC principles.

For the posttest the same 12 multiple choice questions from the pre-test were administered in order to test if there would be a difference in scores after attending the training. In addition to the 12 multiple choice questions, supervisors were asked to rate their own level of comfort and knowledge based on 2 multiple choice questions 1.) As a result of this training my comfort level in utilizing ROC in supervision has A=lessened, B=increased, and C= stayed the same 2.) As result of this training my knowledge on ROC has A=lessened, B=increased, and C= stayed the same. The two questions were then answered with the following multiple choice points. Additionally, supervisors were asked to rate themselves on a 5 point Likert Scale, (1= strongly disagree, 5=strongly agree) responding to three prompts, “I have a good understanding of this principle”, “I feel capable of assisting my supervisee in developing their understanding” in regard to the 10 ROC principles and “how likely are you to use these tools from today’s training in your supervision”.

For the follow up, participants were asked at the end of the posttest, to indicate if they are interested in participating in an online test and self-reported survey follow up. If supervisors indicated they were willing to participate in the follow up, the evaluator contacted supervisors via email with a link to participate in the follow up survey. The survey consisted of the same 12 multiple choice questions from the pretest and posttest in order to test if there would be a difference in scores a month after attending the training. In addition to the 12 multiple choice questions supervisors were asked 11 self-reported multiple choice questions and 5 point Likert scale questions asking how they have been applying the ROC principles and “TIONS” approach to their supervision since the training. The data collected would help to answer the evaluation question of whether the training program assisted supervisors in conceptualizing the principles of ROC.

The first set of data was collected from the North County One Stop Mental Health Clinic in Visalia, CA in March of 2013. The second set of data was collected from the Riverside County Mental Health Department in Riverside, CA April 2013. The third set of data was collect online one month after the training for Fresno site in April. One month was chosen as the third time point because it allowed time for supervisors to implement and practice what they learned in their supervision. Time point 3 for the Riverside site was collect 3 weeks after the training due to time constraints. This time frame was shorter than the Fresno site by a week.

After the data was collected a database was created in Microsoft excel where by the information was input for analysis. Prior to the analysis of the data participants were given an identification code. At the time point 3 participants were given that code in order to identify themselves online.

Data Analysis

The researcher used two forms of data analysis quantitative analysis and qualitative analysis. First, Microsoft Excel 2011 was used to analyze the 12 multiple choice questions for the pre test, posttest and one month follow up. This method of analysis was chosen to examine the average of affirmative responses based on participants answers per question and individually. Second, the researcher analyzed the self-reported survey using the statistical software SPSS 21.0. First, the data were examined for missing data. Where there were more than one missing variables, the entire variable was coded as missing (99). Second, the data was coded for the open-ended questions for the demographics information that asked about percentage of consumers served, SES, and ethnicity was coded (very frequently=90-100%, frequently=75-89%, occasionally=50-74%, rarely=50-0%, and none=0%). The researcher ran frequencies in order to detect how many supervisors responded to each questions and the median response for each item.

CHAPTER SEVEN

RESULTS

The purpose of evaluating the U-ROC Clinical Supervisor training program is to determine effectiveness of the training program with clinical supervisors. Additionally the evaluation will assist the evaluator and developer to further develop the training program and implementation. The purpose of the study was to deliver a training program that would educate and provide supervisors with the necessary tools, knowledge, and skills to further train their supervisees on the use of ROC with their consumers. The evaluation informs the researcher whether the objective of the training program was achieved. The results are discussed according to the location and the time points. Not every participant responded to the on line survey for time point 3. For Visalia, 5 of 7 participants responded and for Riverside 6 of 8 participants responded. The results are based on the responses collected at each time point. Below is a table that indicates the question for the pretest, posttest, and follow up.

Table 3

Pretest, Posttest, and Follow up Questions and Principles

Question Number	Principles and Question
1	Number of principles in ROC (foundational question)
2	Self direction
3	Holistic
4	Individualized and self centered
5	Strength based
6	Empowerment
7	Responsibility
8	ROC intention (foundational question)
9	Non-linear
10	Respect
11	Hope
12	Peer support

Fresno Pre-test

The first U-ROC clinical supervisor-training program was conducted in March of 2013 in Fresno County at North County One Stop Mental Health Clinic in Visalia, California. The training comprised of 7 supervisors. Eighty-six percent of the participants had a Master's degree and 14.3% had a Bachelor degree. Sixty-eight percent of the population were licensed Marital and Family Therapists and 33.3% are licensed Clinical Social Workers. Thirty-three percent of the population supervised for 4 years, 33.3% supervised for 6 years, and 33.3% supervised for 9 years.

The following represents results of the overall scores for participants. Eighty-six percent of the participants were able to affirmatively identify that they are knowledgeable of the number of the principles in ROC. Supervisors score 0% on the principle self-direction. Participants scored 43% on the principle holistic care. Supervisors scored 14% on the following principle individualized and self-centered care. One hundred percent of the participants were able to affirmatively identify the principle strength-based. Supervisors scored 57% of on the principle empowerment. Supervisors also scored 57% on the principle responsibility. Supervisors scored 71% on the question theoretical overlay. Seventy-one percent of participants were able to affirmatively answer the question on the principle non-linear. Supervisors scored the lowest on the following principle respect. Supervisors scored 29% on the principle hope. Additionally, supervisor's scored 71% on principle peer support. The following figure indicates the participant's score at time point 1.

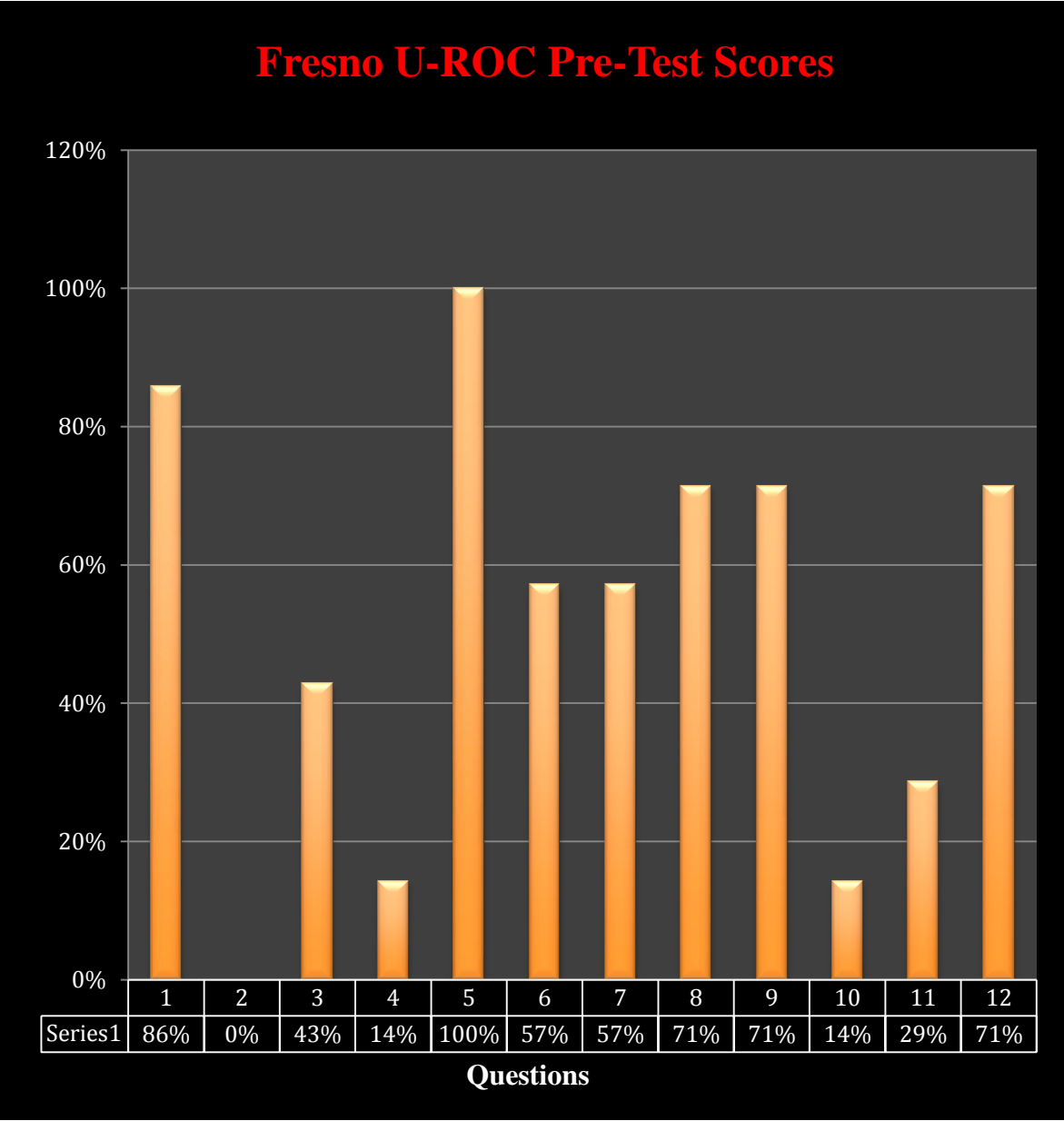


Figure 1. Fresno U-ROC Pre-test Scores

The following are the percentages of scores per supervisor. The highest score indicated were supervisor's numbers 3 and 6 who each scored 67%. Participants 1 and 7 had mid-range scores of 58%. Participants 4 scored 42%. Participants 2 and 5 scored the lowest 33%. The following figure indicates participant's scores at time point 1.

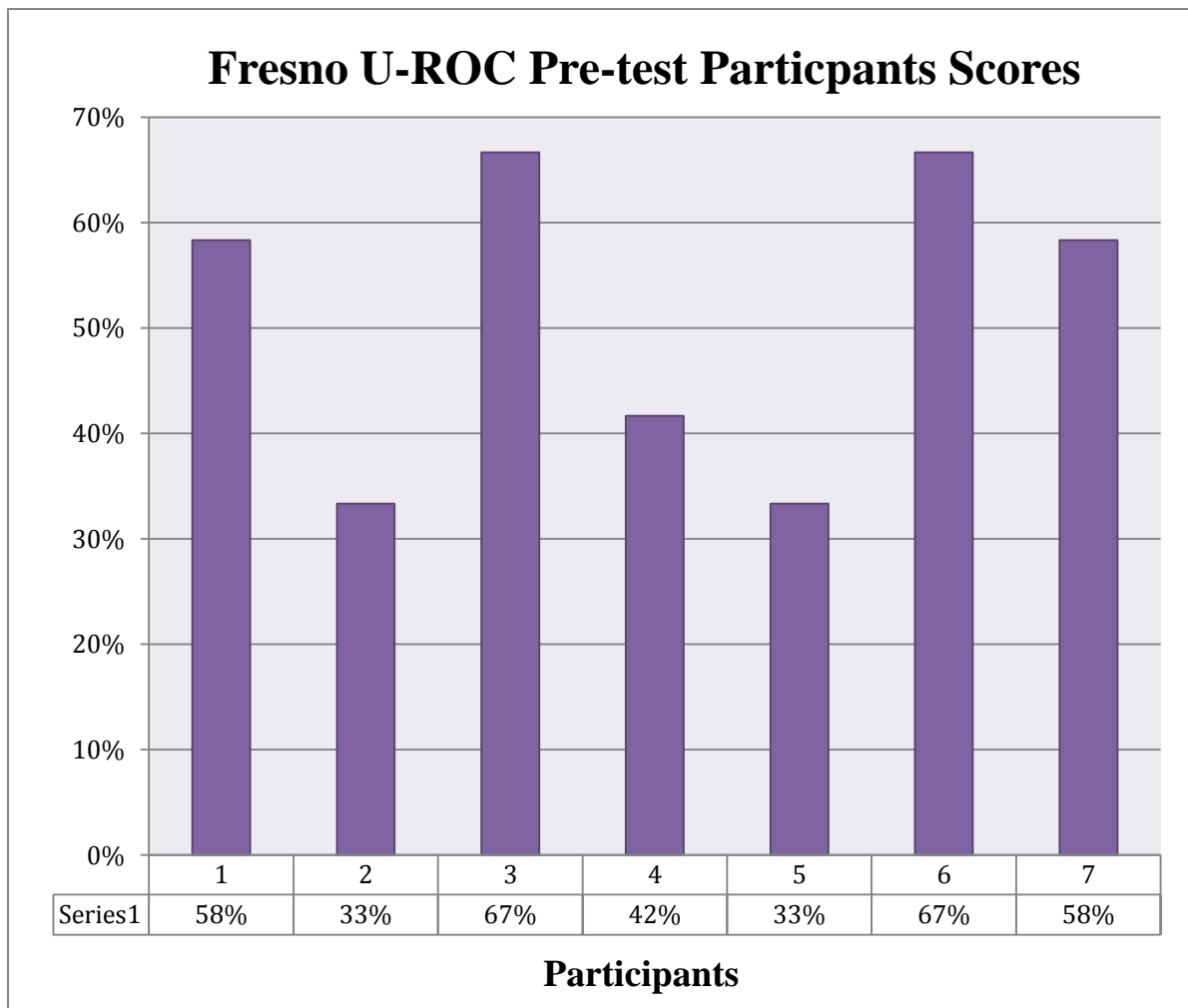


Figure 2. Fresno U-ROC Pre-test Participants

The results from the pre-test for Fresno training indicate supervisors are knowledgeable on the principle following principles strength based and how many principles are part of the approach. Furthermore, the results indicate that supervisors are not knowledgeable on these particular principles self direction, individualized and self-centered, and respect.

Fresno Pre-test Self-Report Survey

On the self-reported survey each principal is considered an item. This is a Likert scale survey (1=strongly disagree, 2=disagree, 3=neutral, 4=agree, and 5=strongly agree). Participants were asked to rate their agreement with this statement. “I have a good understanding of this principle. Participant’s scores indicate that 67% of the population strongly agreed that they have an understanding of the principle ‘hope’ and 53% strongly agree they have a understanding of the principal ‘respect for the consumer’. Participant’s scores indicate that 60% of the population agrees they have an understanding of the principal self-direction, and responsibility. Eighty percent of the participants indicated they strongly disagree with the following principles non-linear, and holistic.

Participants were asked to rate their agreement with this statement “I feel capable of assisting my supervisee in developing their understanding with these principles”. Seventy-one percent of the participants strongly agree they are capable of teaching the principal hope. Fifty-seven percent of the population strongly agrees they are able to teach the principal respect to their supervisees. Fifty-seven percent of the population agreed they are capable of teaching the principles ‘peer support’ and responsibility. Fourteen percent of the population strongly disagreed that they are capable of teaching following principles to supervisees: non-linear, and strength based.

Fresno Posttest

At the time of the posttest 6 supervisors of the Fresno training program participated in the posttest at the end of the 4 hour training program. The following is the results of the overall scores for participants. Eighty-three percent of the participants were able to identify that they are knowledgeable of the number of the principles in ROC. Supervisors score 83% on the principle self-direction. Participants scored 100% on the principle holistic care. Supervisors scored 33% on the following principle individualized and self-centered care. Sixty-seven percent of the participants were able to identify the principle strength-based. Supervisors scored 50% of on the principle empowerment. Supervisors scored 33% on the principle responsibility. Supervisors scored 17% on the theoretical overlay question. Supervisors also scored 17% on the principle non-linear. Supervisors scored the highest (100%) on the following 2 principles respect and hope. Additionally, supervisor's scored 83% on the principle peer support. The following figure indicates the scores of the supervisors at time point 1 and 2 at the end of the 4 hour training program.

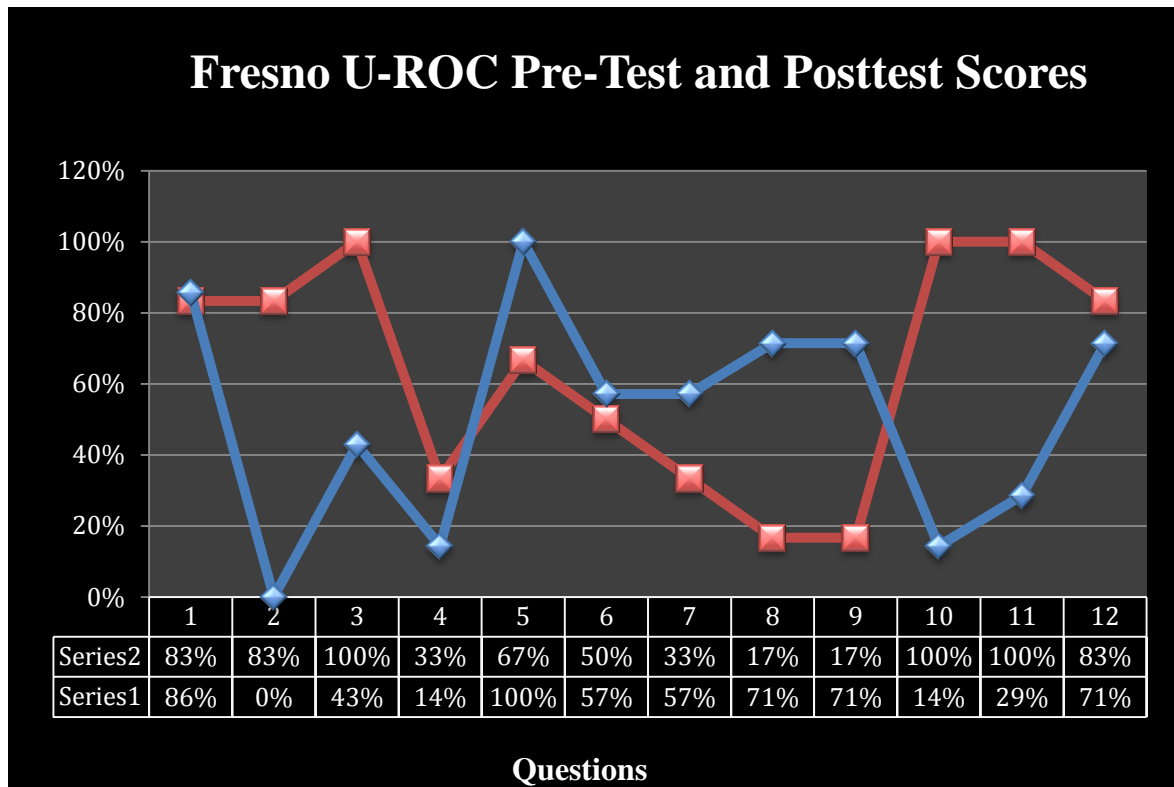


Figure 3. Fresno U-ROC Pre-test and Posttest Scores

The following is the percentages of scores per supervisor. The highest score indicated were supervisors 4 and 5 who each scored 75%. Participant 3 had mid-range score 67%. Participants 2 and 6 scored 58%. Participant 1 scored the lowest 50%. The following figure indicates supervisor's scores at time points 1 and 2.

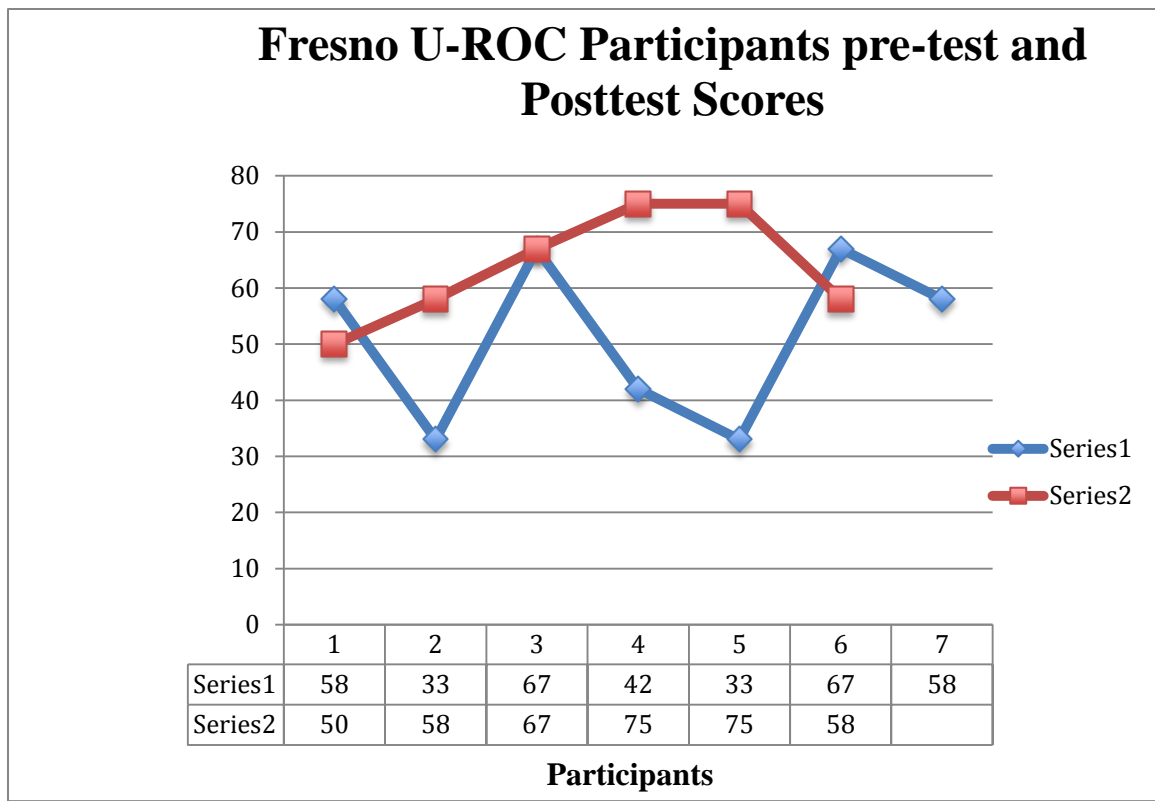


Figure 4. Fresno U-ROC Participant Pre-test and Posttest Scores

The posttest scores indicate that there is improvement in knowledge of 6 questions: self-direction (from 0% to 83%), holistic (43% to 100%), respect (14% to 100%), hope (29% to 100%), peer support (71% to 83%), and individualistic and self centered (14% to 33%). These scores also indicate decrease in knowledge on 6 questions- numbers of principles in ROC (86% to 83%), strength based (100% to 67%), empowerment (57% to 50%), responsibility (57% to 33%), theoretical overlay (71% to 17%), and non-linear (71% to 17%).

When comparing the posttest result for participant's scores, the scores of 3 participants increased, 1 participant's score stayed the same, and the scores of 2

participants decreased. Participant 4's score increased from 42% -75%. Participant 5 score increase from 33%-75%. Participant 2's score increased from a 33%-58%. Participant 3 score stayed the same 67%. Participant 1 score decrease from a 58%-50%. Participant 6 score decrease from 67%-58%.

Fresno Posttest Self-Report Survey

On the self-report survey each principal is considered an item. This is a Likert scale survey (1=strongly disagree, 2=disagree, 3=neutral, 4=agree, and 5=strongly agree). The posttest asked participants the same pre-test Likert scale questions. Participants were asked to rate their agreement with this statement. "I have a good understanding of this principal". Participant's scores indicate that 83% strongly agrees they have an understanding of the following 3 principles: hope, respect for the consumer, and strength based. 50% of the population agrees they have an understanding of the following 4 principles: peer support, non-linear, individualized and self-centered, and self-direction. For the other principles participants indicated a neutral response.

Participants were asked to rate their agreement with this statement "I feel capable of assisting my supervisee in developing their understanding with these principles". Sixty-seven percent of the population strongly agrees they are capable of teaching the following 4 principles: hope, respect, strength based, and responsibility. For the other 6 principles participants agreed with the statement they are capable of teaching: peer support, non linear, individualized and self centered, empowerment, strength based, holistic, and self direction with scores ranging from 20%-50%.

At the time of the posttest supervisors were asked an additional Likert scale question of "how likely are you to use these tools from today's training in your

supervision”. Sixty-seven percent of the population strongly agrees they would use the following 4 tools from the training applications, humanizations, discussions, and reflections. Fifty percent of the population agrees they would use the tool questions in supervision.

Participants were asked an additional 2 multiple choice questions on (1) their level of comfort on utilizing ROC in supervision as a result of the training and (2) their level of knowledge as a result of the training. Supervisor could choose the following answer “a=lessened, b=increased, c=stayed the same. For the level of comfort 100% of the population indicated their level increased. For the level of knowledge 100% of the population indicated their level increased.

Fresno Post Training One Month Follow up

At the time of the one-month follow up, 5 supervisors from the Visalia training program participated in the online follow up. The following are the results of the overall scores for participants. Supervisors scored the highest on these particular principles based on the U-ROC multiple choice test. Participants scored 83% on the 2 questions regarding principles of respect hope. The second highest score was 67% on the following 5 questions: knowledge of number of principles in ROC, self-direction, individualized and self-centered, responsibility, and non-linear. Supervisors scored the lowest on the following 5 questions: holistic (50%) and peer support (50%). Participants scored 17% on the empowerment principle and 0% on the strength based principle as well as the question regarding how ROC can be applied to the supervision process. The following figure indicates the change in scores of supervisors at time points 1, 2, and 3.

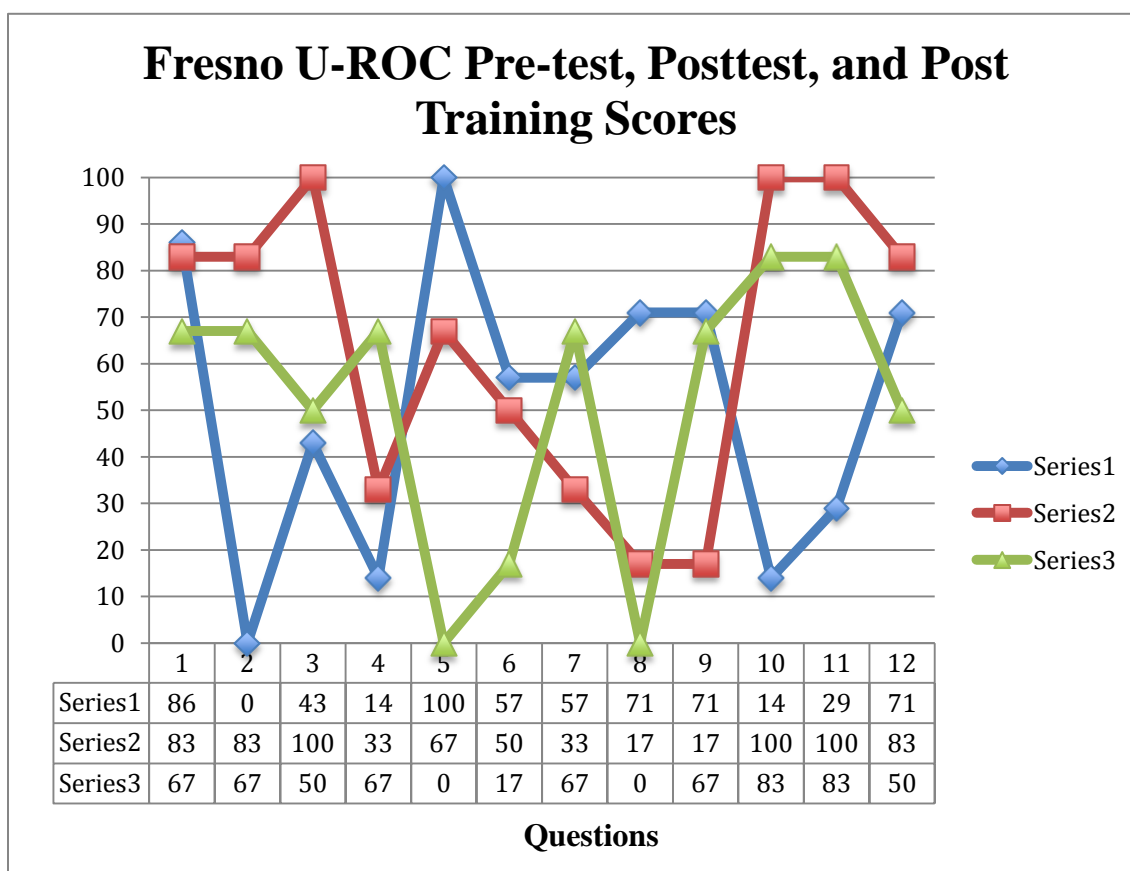


Figure 5. Visalia U-ROC Pre-test, Posttest, and Post Training Scores

The following is the percentages of scores per supervisor. The highest score indicated were supervisor 1 who scored 75%. Participant 6 had mid-range score 67%. Participants 1 and 4 scored 58%. Participant 2 scored the lowest 50%. The following figure indicates the individual scores of the supervisor's at time points 1, 2, and 3.

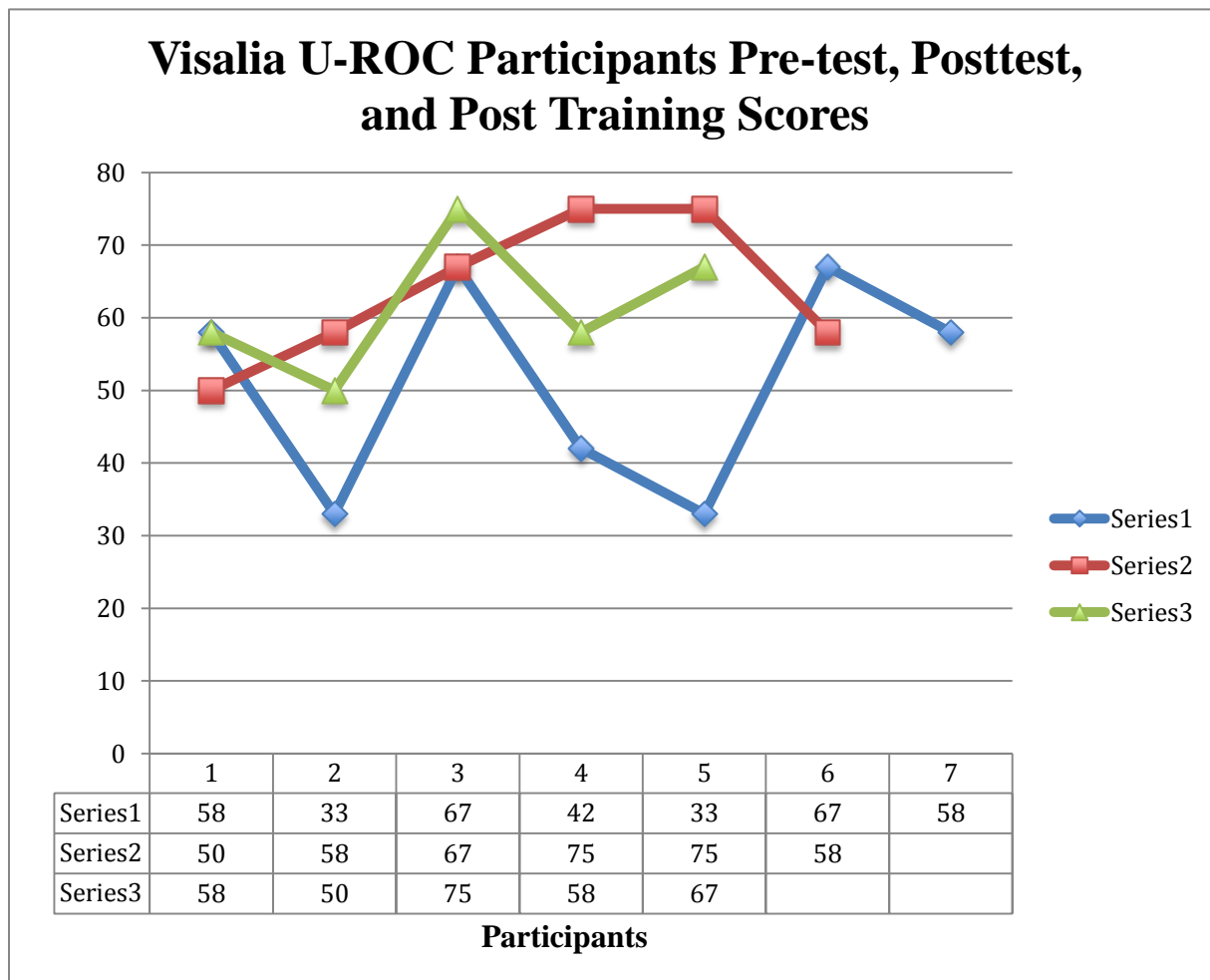


Figure 6. Fresno U-ROC Pre-test, Posttest, and Post Training Participants Score

The one-month follow up scores indicate that there are improvements and decreases in scores over time point 3. Comparing the one month follow up results from the Visalia training supervisors scores indicates improvement in 2 questions and decrease in the 10 questions. Scores improved on the questions individualized and self-centered 67% compared to time point 1 at 14% and time point 2 at 33%. There was an improvement on the question in regards to the principle responsibility 67%. When

analyzing the data the score decrease from time point 1 57% to 33% at time point 2 and was at it highest at time point 3. Ten of the questions scores decrease. Several Scores decrease significantly on the strength based question at 0% as in compared to time point 1 at 100% and time point 2 at 67%. Additionally, the question in regards to how ROC can be applied to the supervision process at 0% compared to time point 1 at 71% and time point 2 at 17%. Each of these particular questions decreased from time point 2 to 3.

When comparing the one month follow up results for participants scores either improved, stayed the same or decrease. 1 participant's score increased, 2 participants scores stayed the same, and 2 participants scores decreased. Participant 6 score increased from its lowest at time point 2 from 58%-67%. Participant 2 score stayed the same at 58% between time 2 and 3. This participant scored the lowest at time point 5 at 33%. Additionally, participant 4 scored stayed the same between time point 2 and 3. This participant scored there lowest at time point 1 with 42%. Participant 3's score decreased from 67% to 50%. This participant scored there highest at time point 2 and 3 with a score of 67%. Additionally, participant 5 scored the lowest at time point 3 at 58% their highest score was at time point 2 with 75%.

Fresno Post Training Self-Report Survey

The self-reported survey asked an additional 8 questions from the pre-test. When asked "since the training if supervisors used any of the "TIONS" approach 71% of the population indicated yes. When asked which of the "TIONS" approach they have attempted to use 80% of the population have attempted to use questions and reflections. Sixty percent indicated they have not attempted using application in their supervision.

When asked which principles have they attempted to use in supervision since the training participants scored 100% indicating the have attempted the following 2 principles

empowerment, and hope. The second highest percentages the scores indicate participants attempt to use are individualized and self centered, and strength based at 80%.

Additionally participants attempted to use holistic, responsibility, and self-direction at 60%. All other principle participants did not indicate they attempted the principles.

Participants were asked to indicate, “Have you made any changes in how you implement recovery oriented care in supervision that is different”? 60% of the population indicated that they have made changes in the how they incorporate ROC in supervision. There was a qualitative written piece to this question that can be found in the qualitative section of the paper. Participants were asked to indicate on a Likert scale how likely they are to continue using the “TIONS” approach in their supervision (1=highly unlikely, 2=unlikely, 3=neutral, 4= likely, and 5=highly likely). 75% of the population indicated that they are likely to continue using “TIONS” and 25% indicated they are highly unlikely to use “TIONS”.

Participants were asked to rate themselves on the following 2 statements using a 5 points Likert scale (1=strongly disagree, 2=disagree, 3=neutral, 4=agree, and 5=strongly agree) “I have a good understanding of this principle after the training”. 80% strongly agrees they have a good understanding of the principles hope and respect for the consumer. Eighty percent agree they have an understanding of the principal responsibility and 60% agrees they have an understanding of the principles holistic and non-linear. For the other 5 principles supervisors were neutral on their understanding. “I feel capable of teaching my supervisee the following principles after the training.” Sixty percent of Participants strongly agrees they can teach the following principles empowerment,

strength based, and respect for the consumer. Eighty percent of participants agree they can teach the principle non-linear.

Participants were asked to score themselves on a 5-point Likert scale (1=strongly decrease, 2=decrease, 3=stayed the same, 4=increase, and 5= strongly increase) to “what extent has your knowledge of recovery oriented care principles increased”. Sixty percent of participants indicated that their knowledge of ROC increased. Participants were asked to score themselves on this multiple choice question (not at all, barely, neutral, fairly well, and very well). “To what extent have you learned how to incorporate recovery oriented care principles in your supervision”? Sixty percent of participants indicated that they have learned fairly to incorporate ROC in their supervision.

Participants were asked to score themselves on a 5 point Likert scale (1=strongly disagree, 2=disagree, 3=neutral, 4=agree, and 5=strongly agree) “Which of the recovery oriented care principles do you plan to continue implementing in your supervision”? Eighty Percent of participants indicated they agree that they will continue using the following principles respect, hope, strength based, non-linear, holistic, and responsibility. Participants were asked to rate length of training (too short, short, just right, long, and too long). Eighty percent of participants indicated that the 4 hour training program was just right and 20% indicated that the training was too short.

Fresno Qualitative Results

Supervisors were asked a quantitative question at time point 3 of “Since the training, have you made any changes in how you implement recovery oriented care in supervision that is different” if they answered yes to the questions they were asked to qualitatively indicate what are those changes. Supervisors reported that they are thinking

first about which principles applies to the case their supervisee is processing with them, modeling how to develop mutual relationship with consumers, providing students with more instructions and questions to assist in the conceptualization of the principles.

Riverside Pre-test

The second U-ROC clinical supervisor-training program was conducted in April of 2013 in Riverside County at the Riverside County Department of Mental Health in Riverside, California. The training comprised of 8 supervisors. Of the population 85.7% has a Master's degree and 14.3% has a Doctoral degree. Fifty-seven percent of the population are licensed Clinical Social Workers, 14.3% are licensed Marriage and Family Therapist, 14.3% are licensed clinical psychologist, and 14.3% is licensed in other fields. The population was broken down equally at 16.7% for supervisors providing supervision ranging from 2-37 years.

The following represents results of the overall scores for participants. Thirty-eight percent of the participants were able to identify that they are knowledgeable of the number of the principles in ROC. Supervisors scored 100% on the principle self-direction. Participants scored 75% on the principle holistic care. Supervisors scored 75% on the following principle individualized and self-centered care. Thirty-eight percent of the participants were able to identify the principle strength-based. Supervisors scored 88% of on the principle empowerment. Supervisors also scored 50% on the principle responsibility. Supervisors scored 38% on the question theoretical overlay. Sixty-three percent of participants were able to answer the question on the principle non-linear. Supervisors also scored 63% on the principle respect. Supervisors scored 75% on the

principle hope. Supervisors scored the lowest on the following principle peer support 0%.

The following figure indicates the participant's score at time point 1.

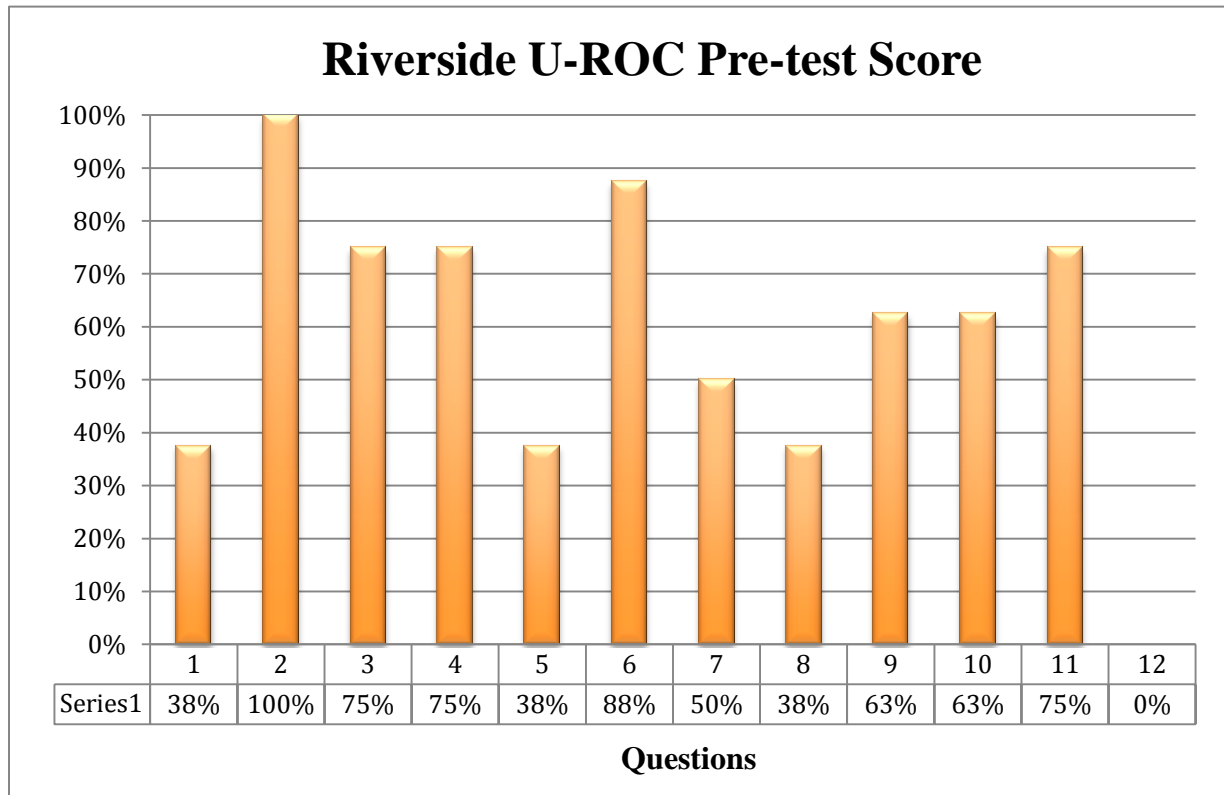


Figure 7. Riverside U-ROC Pre-test Score

The following is the percentages of scores per supervisor. The highest score indicated were supervisor 7 who scored 83%. Also, supervisor 3 had the second highest scored at 75%. Supervisors 2 and 3 had a score of 67%. Participant 1 scored 58%. Participants 2 and 4 had mid-range score of 42%. Participant 5 had the lowest score 33%. The following figure indicates the individual scores of the supervisor's at time point 1.

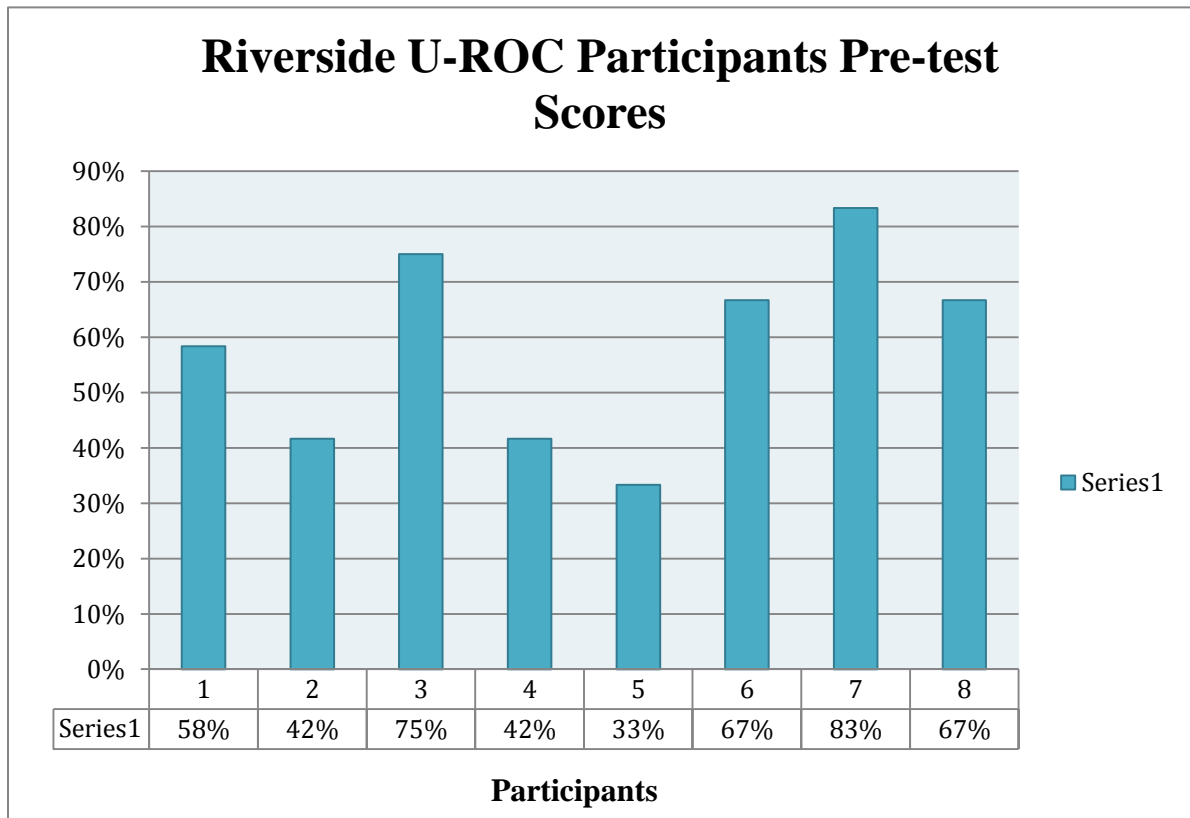


Figure 8. Riverside U-ROC Pre-test Participants Scores

The results from the pre-test for Riverside training indicate supervisors are knowledgeable on the principle following principles self-direction, empowerment, non-linear, and respect based on the percentage they receive on the U-ROC multiple choice test. Furthermore, the results indicate that supervisors are not knowledge on these particular principles peer support, and strength based.

Riverside Pre-test Self-Report Survey

On the self-reported survey each principle is considered an item. This is a 5 points Likert scale survey (1=strongly disagree, 2=disagree, 3=neutral, 4=agree, and 5=strongly agree). Participants were asked to rate their agreement with this statement. “I have a good understanding of this principal”. Participant’s scores indicate that 63% of the population strongly agreed that they have an understanding of the principles hope, respect, and peer support. Participant’s scores indicate that 75% of the population agreed they have an understanding of the principle responsibility.

Participants were asked to rate their agreement with this statement “I feel capable of assisting my supervisee in developing their understanding with these principles”. Sixty-two percent of the participants strongly agreed they are capable of teaching the principles hope, respect, peer support, and strength based. Fifty percent of the population agreed they are capable of teaching the following to supervisees: individualized and self-centered, empowerment, responsibility, and self-direction.

Riverside Posttest

At the time of the posttest 8 supervisors of the Riverside training program participated in the post-test at the end of the 4 hour training program. The following is the results of the overall scores for participants. One hundred percent of the participants were able to identify that they are knowledgeable of the number of the principles in ROC. Supervisors score 100% on the principle self-direction. Participants scored 83% on the principle holistic care. Supervisors scored 63% on the following principle individualized and self-centered care. Eighty-eight percent of the participants were able to identify the principle strength-based. Supervisors scored 100% on the principle empowerment.

Supervisors scored 63% on the principle responsibility. Supervisors scored 88% on the theoretical overlay question. Supervisors also scored 88% on the principle non-linear. Supervisors scored the highest (100%) on the following 2 principles respect and hope. Additionally, supervisor's scored 50% on the principle peer support. The following figure indicates the scores of the supervisors at time point 1 and 2 at the end of the 4 hour training program.

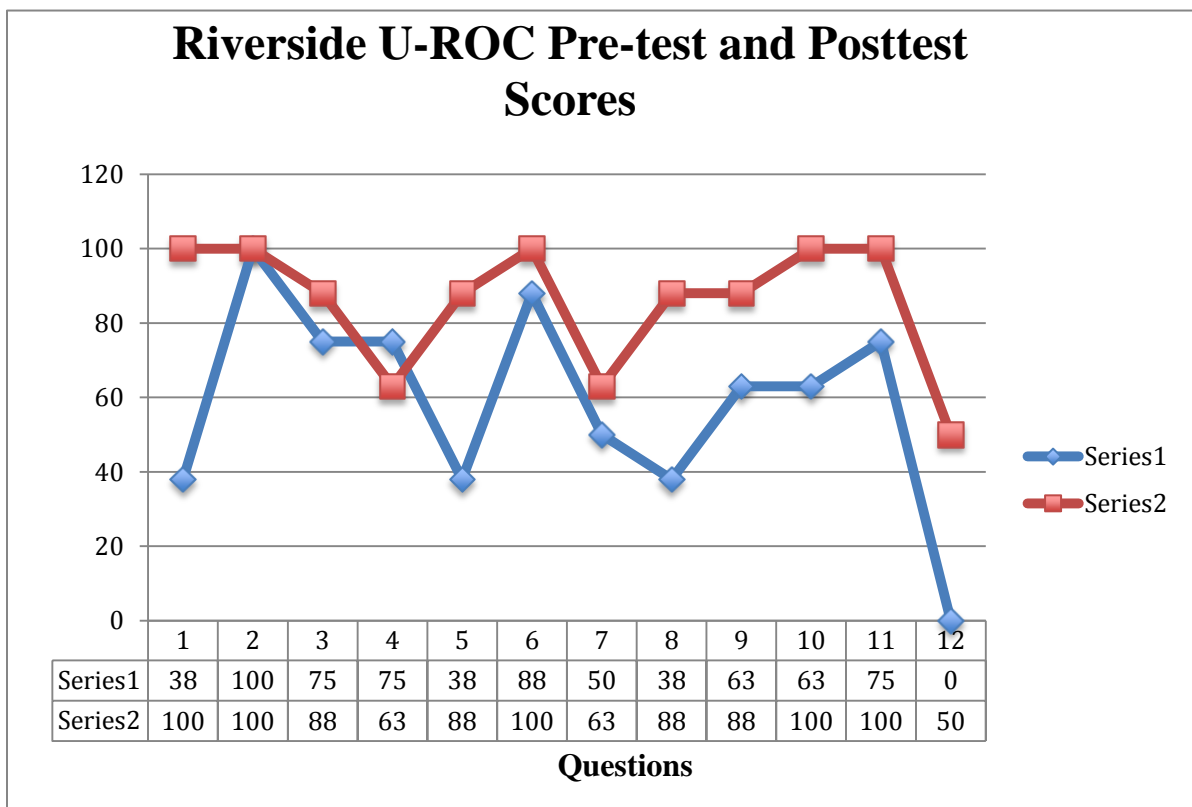


Figure 9. Riverside U-ROC Pre-test and Posttest Scores

The following is the percentages of scores per supervisor. The highest score indicated were supervisors 1 and 6 who scored 100%. Supervisor 5,7, and 8 scored the

second highest score of 92%. Participant 3 had a score of 75%. Participants 2 and 4 had the lowest scores 67%. The following figure indicates the individual scores of the supervisor's at time points 1 and 2.

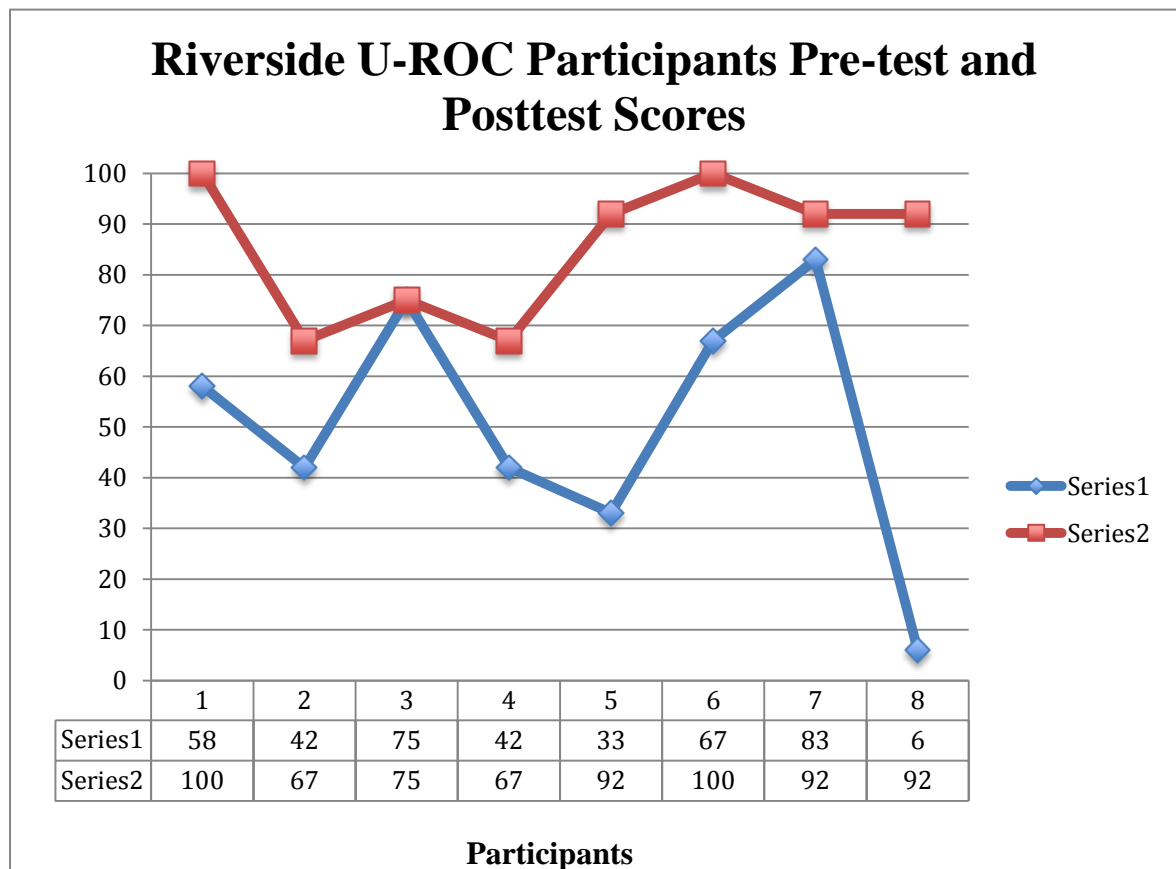


Figure 10. Riverside U-ROC Participants Pre-test and Posttest Scores

When comparing the posttest results from the Riverside training posttest supervisor's scores indicates that there is improvement in participants scores based on an increase in 10 questions of the 12 questions. Number of principles (38% to 100%), empowerment (88% to 100%), Respect (63% to 100%), hope (75% to 100%), holistic

(75% to 88%), strength based (38% to 88%), responsibility (50% to 63%), knowledge of ROC application in supervision (38% to 88%), non linear (63% to 88%), and peer support (0% to 50%). Scores stayed the same at 100% on the principle self-direction. Individualized and self-centered score decreased to 63% to 75% compared to time point 1.

When comparing the posttest result participants scores either improved, stayed the same or decrease. 6 participants score increase, 1 participant score stayed the same, and 1 participants score decreased. Participant 1 score increase from 58% -100%. Participant 6 score increase from 67%-100%. Participants 5 from 33%-92, participant 8 from a 67%-92%, participant 4 score 42%-67%. Participant 3 score stayed the same 75%. Participant 2 score decrease from a 67%-42% and participant 6 from 67%-58%.

Riverside Self-Report Survey

On the self-report survey each principal is considered an item. This is a Likert scale survey (1=strongly disagree, 2=disagree, 3=neutral, 4=agree, and 5=strongly agree). The posttest asked participants the same pre-test Likert scale questions. Participants were asked to rate their agreement with this statement. "I have a good understanding of this principal". Participant's scores indicate that 100% of the population strongly agrees they have an understanding of the following 9 principles self-direction, empowerment, holistic, responsibility, hope, respect, peer support, non-linear, and strength based. For the principle individualized and self-centered participants indicated a neutral response.

Participants were asked to rate their agreement with this statement "I feel capable of assisting my supervisee in developing their understanding with these principles". Eighty-three percent of the population strongly agrees they are capable of teaching the

following 9 principles self-direction, empowerment, holistic, responsibility, hope, respect, peer support, and strength based. Participants responded neutral for the principle individualized and self-centered.

At the time of the posttest supervisors were asked an additional Likert scale question of “how likely are you to use these tools from today's training in your supervision”. Eighty-three percent of the population strongly agrees they would use the following 3 tools from the training humanizations, discussions, and reflections. Sixty-seven percent of the population agrees they would use the tools questions and applications in supervision.

Participants were asked an additional 2 multiple choice questions on (1) their level of comfort on utilizing ROC in supervision as a result of the training and (2) their level of knowledge as a result of the training. Supervisor could choose the following answer “a=lessened, b=increased, c=stayed the same. For the level of comfort 100% of the population indicated their level increased. For the level of knowledge 75% of the population indicated their level increased. Twelve percent indicated their knowledge stayed the same and 12% indicated their knowledge decreased.

Riverside Post Training

At the time of the one-month follow up, 6 supervisors from the Riverside training program participated in the online follow up. The following are the results of the overall scores for participants. Supervisors scored the highest on these particular principles based on the U-ROC multiple choice test. Participants scored 75% on the following 5 questions: respect, hope, holistic, empowerment, and number of principles in ROC. The second highest score was 63% on the principle individualized and self-centered. Supervisors

scored the lowest on the following 5 questions. Participants scored 50% the principles self-direction, and strength based, responsibility, and knowledge of how ROC can be used as a overlay for supervision. Participants scored 38 % on peer support. The following figure indicates the change in scores of the supervisors at time point 1, 2, and 3 at the end of the 4 hour training program.

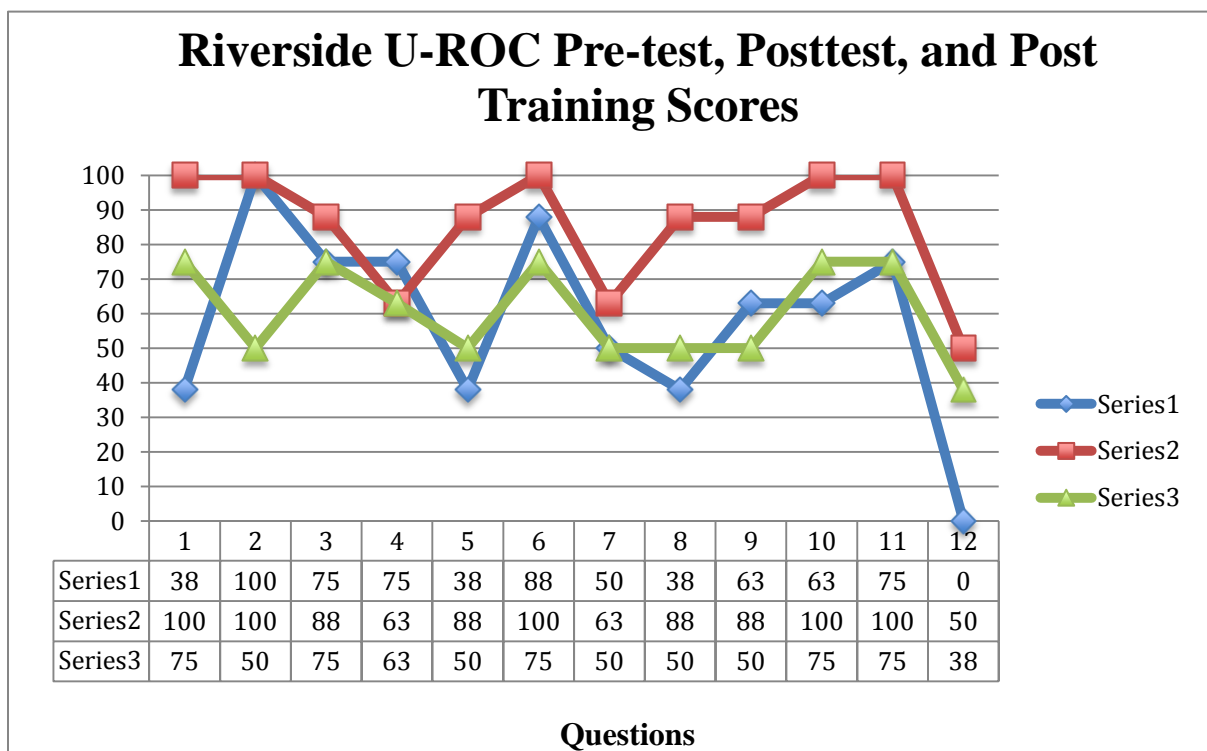


Figure11. Riverside U-ROC Pre-test, Posttest, and Post Training Scores

The following is the percentages of scores per supervisor. The highest score indicated were supervisors 3, 5, and 6 who scored 92%. Supervisor 3 had the second highest score of 83%. Participant 4 scored 75%. Participant 1 had the lowest score of

67%. The following figure indicates the individual scores of the supervisor's at time point 1, 2, and 3.

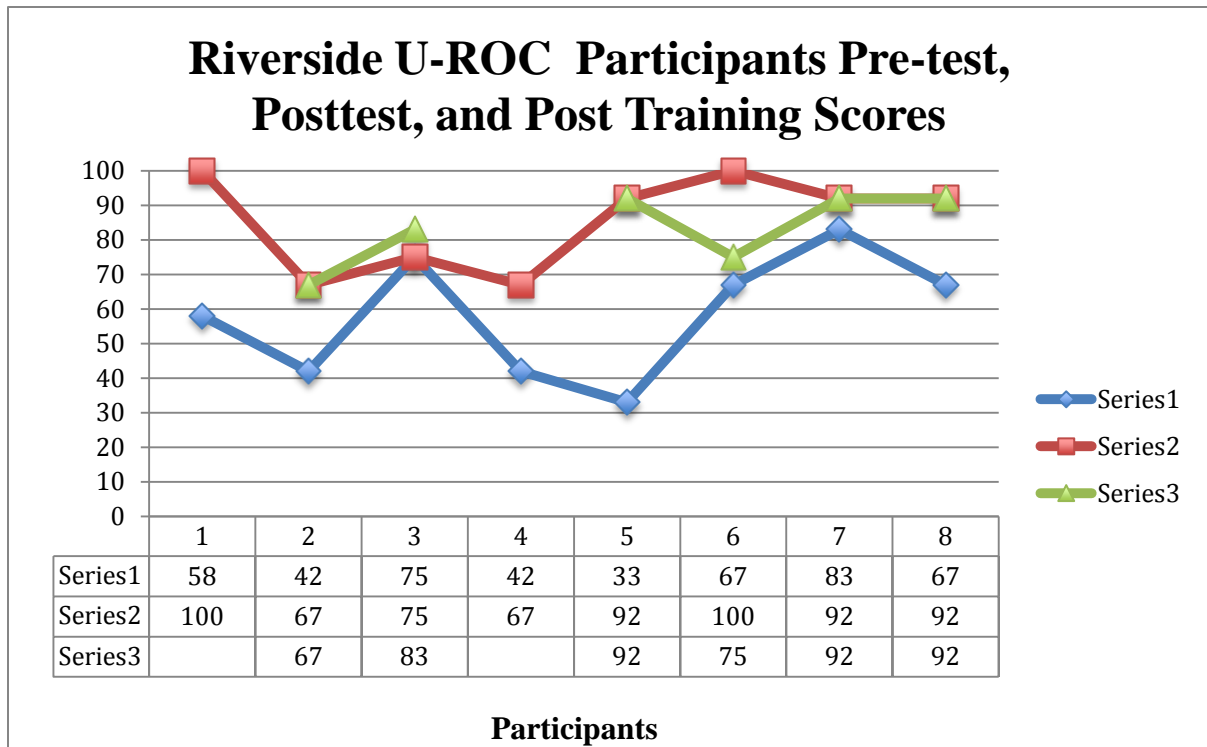


Figure 12. Riverside U-ROC Participants Pre-test, Post Training and Post Training Scores

The one-month follow up scores indicate that questions scores stayed the same. Eleven of the scores decreased in time point 3. Comparing the one month follow up results from the Riverside training supervisors scores stayed the same on individualized and self centered at 63%. Eleven of the scores between time point 2 and 3: number of principle in ROC (100% to 75%), self-direction (100% to 50%), holistic (88% to 75%), strength based (88% to 50%), empowerment (100% to 75%), responsibility (63% to

50%), knowledge of ROC (88% to 50%), non-linear (88% to 50%), respect (100% to 75%), hope (100% to 75), and Peer support (50% to 38%).

When comparing the one month follow up results for participants scores either improved, stayed the same or decreased. One participant score increased, 4 participant score stayed the same, and 1 participant score decreased. Participant 6 score increase from its lowest at time point 2 from 75% -83%. Participant 5,7, and 8 scores stayed the same at 92% from time point 2. Additionally, participant 2 score stayed the same at 67%. Participant 6 score decreased from time point 2 from 100% to 75%.

Riverside Post Training Survey

The self-reported survey asked an additional 8 questions from the pre-test. When asked “since the training if supervisors used any of the “TIONS” approach 100% of the population indicated yes. When asked which of the “TIONS” approach they have attempted to use 80% of the population has attempted to use questions. Sixty percent indicated they have not attempted using discussions or humanizations in their supervision. Forty percent indicated they have not attempted application. When asked which principles have they attempted to use in supervision since the training participants scored 100% indicating they have attempted the following 2 principles empowerment, and hope. The second highest percentages the scores indicate participants attempt to use are responsibility, peer support, and strength based at 80%.

Participants were asked to indicate, “Have you made any changes in how you implement recovery oriented care in supervision that is different”? Sixty-six percent of the population indicated that they have made no changes in the how they incorporate ROC in supervision. Participants were asked to indicate on a Likert scale how likely are they to

continue using the “TIONS” approach in their supervision (1=highly unlikely, 2=unlikely, 3=neutral, 4= likely, and 5=highly likely). Fifty percent of the population indicated that they are likely to continue using “TIONS”. Thirty three percent indicated they are highly likely to use “TIONS” and 16% indicated they are highly unlikely to use “TIONS”.

Participants were asked to rate themselves on the following 2 statements using a 5 points Likert scale (1=strongly disagree, 2=disagree, 3=neutral, 4=agree, and 5=strongly agree) “I have a good understanding of this principle after the training”. 83% strongly agrees they have a good understanding of the principles hope, strength based, empowerment, and respect for the consumer. Thirty three percent agree they have an understanding of the principles holistic and self-direction. The second statement, “I feel capable of teaching my supervisee the following principles after the training.” Fifty percent of Participants strongly agrees they can teach the following principles hope, non-linear, and respect for the consumer. Sixty seven percent of participants agree they can teach the principles self-directions, and strength based.

Participants were asked to score themselves on a 5-point Likert scale (1=strongly decrease, 2=decrease, 3=stayed the same, 4=increase, and 5= strongly increase) to “what extent has your knowledge of recovery oriented care principles increased”. Eighty-three percent of participants indicated that their knowledge of ROC stayed the same.

Participants were asked to score themselves on this multiple choice question (not at all, barely, neutral, fairly well, and very well). “To what extent have you learned how to incorporate recovery oriented care principles in your supervision”? Fifty percent of

participants indicated that they have learned fairly well to incorporate ROC in their supervision.

Participants were asked to score themselves on a 5 point Likert scale (1=strongly disagree, 2=disagree, 3=neutral, 4=agree, and 5=strongly agree) “Which of the recovery oriented care principles do you plan to continue implementing in your supervision”? Sixty-seven percent of participants indicated they strongly agree that they will continue using all of the 10 principles of ROC. Participants were asked to rate length of training (too short, short, just right, long, and too long). Thirty-three percent of participants indicated that the 4 hour training program was too short, 33% short, and 33% just right.

Riverside Qualitative Results

Supervisors were asked a quantitative question at time point 3 of “Since the training, have you made any changes in how you implement recovery oriented care in supervision that is different” if they answered yes to the questions they were asked to qualitatively indicate what are those changes. Supervisors reported that they are aware of the principles when talking with supervisees, able to break down the principles into smaller steps, slow down the process of supervision when discussing ROC, listen, and provide students with more instructions and questions to assist in the conceptualization of the principles.

CHAPTER EIGHT

DISCUSSION

The goals and objectives of the U-ROC supervisor clinical training program were met based on the results from the evaluation of the U-ROC multiple-choice test and self-report survey. Results indicated that all participants that went through the one day 4 hour training program were knowledgeable of the background of ROC as indicated at time point 2. Participants showed improvements in their knowledge of ROC prior to the training, as indicated by an increase in percentage at time point 2. Supervisors were knowledgeable of the 10 principles and have at least one new way to apply the principles in supervision at time point 2 and time point 3 as indicated that they will use one of the “TIONS” approaches in their supervision. The objective of supervisor’s ability to discuss how the principles apply to the process of supervision was met through role-plays that took place at the second training and results from the self-reported survey questions at time points 1, 2, and 3.

Supervisors were able to (1) demonstrate that they are aware of the different principles and their meaning (2) utilize the principles in supervision (3) gain a greater knowledge of the applications of the principles by practicing and utilizing the various skills learned from the training. As indicated by the results from time point 3 where supervisors take the “TIONS” approach and utilize different tools to assist in conceptualization of the approach for both themselves supervisees. The training helped to validate supervisor’s ideas of how ROC can be used and provided them with a deeper understanding of the different tools and mechanisms they attempt in supervision.

In reviewing the results from the Fresno training, scores increased from time point 1 to time point 2. Participant scores for each question went up drastically from a cumulative score of 0% to 83% on the self-direction principle, 14% to 100% on the respect principle. Overall scores improved from time point 1 to time point 2. When comparing scores between time points 1, 2, and 3 scores decreased slightly at time point 3. The scores from the Riverside training increased from time point 1 to time point 2. Similar to the Fresno scores, there was a slight decrease in scores for time point 3.

There are three possible factors that may have contributed to the decrease in scores over the three time points. First, there is a possibility supervisor's did not retain the information post training and did not implement the principles and or tools they learned. Second, environmental factors at the time of testing may have contributed to the decrease in scores. Finally, the level of stress the supervisor was under while taking the test may have contributed to the decrease in scores from time point 2 to time point 3.

The decrease in participant's scores may be contributed an issue of information retention over time. Generally, individuals retain approximately 70% of information they learn. Furthermore, individuals retain less than 20% of what they learned in the last 10 minutes of a presentation (McKeachie, 1986, p.72). According to Rickard, Rogers, Ellis, and Beidelman (1988), individuals can best retain information when they are able to utilize information they learn. If individuals are active after learning information and repeat the information it is more likely they will retain that information. Additionally individuals retain more when they are able to discover, investigate, and interpret for themselves information they have learned. If supervisors were able to go back to their

respective supervision situations and implement the information they learned there is a possibility their scores would not have decreased at time point 3.

Another explanation for scores decreasing is individuals forgetting information that is not used over a certain period of time (Ortega-Castro & Vadillo, 2012). A research study was conducted with 94 undergraduate students from the University of Duesto, in which they were asked to recall information (groups of words, long sentences, and pictures) over 6 different time points during the day of the study. Students were not able to recall all of the information at all of the time points. The researchers attributed this detriment to what they call “Retrieval Induced Forgetting (RIF)”. RIF is defined as a way in which cognitive control system occurs. According to Hicks and Starns (2004), forgetting information is beneficial in that it reduces the likelihood of an individual cognitive system overloading and not being able to store information. One of the benefits of RIF is a person may recall the information when necessary (Ortega-Castro, & Vadillo, 2012). The decrease in scores overtime on the U-ROC multiple-choice test can possibly be attributed to RIF. Supervisors may not have used the principles post training and the information was stored away. Subsequently, a month of the information being stored away supervisors was unable to recall the principles when taking the test because the information was inactive.

According to Roediger and Butler (2010), if information is ignored after training or learning then the likelihood of being able to retrieve the information when needed decreases. The sooner information is recalled after a training the more likely an individual will be successful in retaining and applying the information. Another factor that may have contributed to the decrease in post training results are environmental

factors such as supervisors being able to practice and share what they learned in the training with their co-workers or supervisees. According to Williams, Turrell, and Wall (2002), an individual's environment contributes to how well that individual retains information after attending a training. Additionally, a part of the process of individuals recalling and retaining information is the training environment itself and how well the trainers empower participants to incorporate what they have learned in the training into their daily work activities. Trainers should also provide participants opportunities within the training itself to link training information to their daily work activities and supervisory experiences. An individual that returns to a work environment that is conducive to share the information they learned at training and be innovative with the material learned is more likely to practice and recall information when needed. Other environmental factors may include noise and the presence of other individuals surrounding the training space at the time of the test. The atmosphere in which individuals take a test in must be conducive to test taking (Baddley, 2000). At time point 2 at the Fresno site, participants were in a room that was less than ideal test taking. There was a sporadic foot traffic in the training room at the at the time of the training, pre and post tests as the training room at this site was in the middle of the offices and kitchen. At the Riverside office, when individuals finished their test they were noisy, packing up and talking with one another. Therefore, it may be projected that participant's experiences similar environmental factors at the third time point.

The third factor that may have contributed to a decrease in scores is the level of work or personal stress the supervisor was under post training and the time of the test. Stress has been shown to play a crucial role in how an individual learns and on memory

performance (Joels, Pu, Wiegert, Oitzl, & Krugers, 2006). If a person is part of an environment that is stressful then it may be hard for them to have an optimal cognitive performance (Lynch, 2004). Another factor related to stress is test anxiety, also known as situational anxiety, or evaluation anxiety (Cassady & Johnson, 2000). Test anxiety affects about 25% to 40% of individuals (Lee, 1999). Test anxiety may have prevented participants from achieving optimal scores because anxiety was high at the time of the test.

Given the low scores at time point 1 at both sites, it is clear that supervisors are in need of the foundational information about ROC offered in this training. There was a decrease in scores from time point 2 to time point 3 on the foundational questions on the U-ROC multiple-choice test. In order for participants to retain the information they are in need of consistent exposure to the 10 ROC principles. One individual from the Riverside training indicated in her discussion that in order for her to remember the principles she would have to write them out for herself and memorize them. This is an example of a participant who is engaging in active learning. In the training the participants were advised to incorporate a principle each week either in supervision or staff meetings. From delivering this training to both sites, it was gathered that the participants want to learn about role changes, language of ROC, and validation of the tools they may use to teach their supervisees ROC.

The questions and needs of supervisors can be linked back to Symbolic Interactionism, the theoretical framework from which this project was developed. Symbolic interactionism discusses the role that individuals have and explores how individuals interact with one another in their world and create meaning. The concepts of

symbolic interactionism can be applied to the training of how the interaction between supervisors and interns help shape the world in which they interact with one another (LaRossa & Reitzes, 1993). Supervisors are the ones that create the environment in which the intern will enter and interact with during the period of supervision. This theory allowed for the developer of the training program to teach supervisors how to create meaning in their supervision when applying ROC and validating the ideas and tools that are discussed in the training program. Based on the qualitative results from each site, supervisors are taking the information from the training and applying it to their world in order to shape the process of supervision. Together supervisors and their supervisees are creating meaning and an understanding of how ROC applies to their cases. The quantitative results also demonstrated that supervisors are applying the “TIONS” approach and making meaning of the approach for themselves. One supervisor reported that she would take the “TIONS” approach and rewrite them for herself in order for her to model and teach the principles to her supervisees.

Some of the findings associated with the evaluation from both trainings indicate that supervisors are aware of ROC but are unaware of how to utilize the principles in supervision. Prior to the training supervisors agreed that they have a good understanding of the 10 principles. There were mixed responses from participants on feeling capable of teaching the principles to their supervisee. Participants either stayed neutral or agreed that they knew how to teach the principles. At time point 3 participants reported that they either agreed or strongly agreed they have an understanding of the principles and feel capable of teaching their supervisee the principles. The scores at time points 2 and 3

indicate that supervisor's level of knowledge and confidence increased in being able to both practice and teach the principles to his or her supervisee.

There was a mixed report on participant's opinion of the length of the training. Participants either reported that the training was too short or that it was just the right length. This informs the researcher how to further develop the U-ROC training program. In the future, this training program will remain 4 hours long, however be delivered over a period of 3 trainings. This approach to the training will give supervisors an opportunity to apply the principles they learn in their supervision or with others at their site.

The self-reported survey was part of the one-month follow-up tested for program effectiveness and sustainability. The results indicate that participants are using some of the "TIONS" approach including, questions, reflections, and discussions as a part of supervision. It is possible that supervisors are more likely to use these particular "TIONS" approaches because they were already using them in their supervision. According to Wozniak and Gorzelanczyk (1994), individuals are less likely to step out of their comfort zone because of entrenched learned behavior or familiarity. Individuals are more prone to repetition of information and the way in which they practice their work. It is possible for supervisors who are comfortable with these approaches to not be willing to take a risk and try the other two approaches. Further qualitative analysis needs to be done in order for the researcher to investigate and conceptualize the reasons participants are not using the other two "TIONS", applications and humanizations. Participant's scores also indicate that the principles supervisors use the most in supervision are empowerment, strength based, hope, self-direction, and individualized and self-centered.

Supervisors reported they are attempting to incorporate principles peer support and non-linear in their supervision.

Based on the results from the self-report survey respondents are willing to continue to incorporate both the “TIONS” approach and the 10 ROC principles in their supervision process. There are commonalities in the two sites as to how they felt the training assisted in their incorporation of the ROC in supervision. Those commonalities include supervisors became more aware of how they are using ROC in their supervision, slowing down the process of supervision when using ROC, and using the same 3 “TIONS” approaches in their work. The feedback from the evaluation allows for the researcher to continue exploring barriers or factors that prevent supervisors from incorporating ROC in their supervision routinely or as a part of how they conceptualize cases. For example, the humanization of working with consumers, making the supervision process one that is parallel to teaching supervisee how to apply ROC, and assisting supervisors with the common pitfalls of counter-transference that can occur at the supervision level and the consumer level when using any of the 10 principles.

The results from the question during the one-month follow up of “have supervisors made changes in their incorporation of ROC” suggest that the program is effective. Participants responded they are aware of ROC in their supervision, and are able to teach their supervisees how to recognize the principles and apply them. In order to reach sustainability the length of the training program needs to be extended. This would give participants the opportunity to effectively grasp the information they are learning. Additionally an extension of the program would allow for the trainer to engage the participants in active learning activities rather than lecture alone.

While both clinical populations are similar in that they each provide services to the severely mentally ill, receive MHSA funding, and have supervisors that are BBS approved, they are different in the amount of years participants have supervised. At the Fresno site, the supervisor with the most years of supervision had 9 years of experience as compared to supervisor in Riverside who had 37 years supervisory experience. The scores from the multiple choice test indicate that overall participants from both sites struggled with the peer support, holistic, and non-linear principles. These scores were consistently low across the 3 time points.

Fresno and Riverside scores indicate that they are similar in the U-ROC pre-test because they both had scores in which they received 0%. In contrast Riverside scores indicate that they scored higher on more questions than Fresno. The posttest scores indicate that participants had similarities in scores on the principles respect and hope at 100%. Additionally they both scored high on the number of ROC principles as well as self-direction and holistic ranging from 88%-100%. The post training scores indicate similarities in that they each had scores under 50%. In contrast Fresno had highest scores that fell in the 83% range compared to Riverside's highest score of 75%.

The researcher believes that the participants possibly scored high on the principles strength based, hope, holistic and self-direction because these are principles they may already be practicing in their work with consumers or in supervision. The U-ROC clinical supervisors training program was developed for supervisors that are both inexperienced and experienced in using ROC. Therefore it is not surprising that supervisors would score high on some of the principles and low on others.

Each training site is different in how they incorporate ROC in their work. They are each developing how ROC fits into their supervision process. The learning and incorporation of ROC is an ongoing process as the approach is unique and allows room for individuals to adapt the approach for themselves. The information gathered from the data in this study will help to further develop the U-ROC clinical supervisors training program in order to continue furthering the learning process of ROC being utilized in supervision.

CHAPTER NINE

IMPLICATIONS AND RECOMMENDATIONS

Implications

The results of this project have emphasized a need to continue educating supervisors on how to incorporate the 10 principles of ROC in supervision. The program met its goals of educating and providing supervisors with the necessary tools, knowledge, and skills to further train their supervisees on the use of ROC with their consumers. The researcher believes the results from the evaluation have implications for the field of Marriage and Family Therapy and future research.

The Field of Marital and Family Therapy

This project has significant contribution to the field of MFT. ROC is not new to the field. Individuals that work within the field already have the tools necessary for implementing ROC in their work based on their theory of practice and the basic foundation they have learned on how to conduct therapy. ROC is an overlay for the way in which individuals work. The project gives those in the field of MFT increased knowledge of how they can apply ROC to their work. Furthermore, it gives MFT's the necessary tools and skills they can use to incorporate ROC in their work, including use of questions, metaphors, and roleplaying. This project can be beneficial to the field of Marital and Family therapy in further enhancing the knowledge and building upon already existing clinician skills.

This project helps in the development of educational curriculum that could be incorporated in the training of MFT supervisors. Additionally, there is a need to continue

educating MFT's on ROC and giving them an opportunity to: (1) learn how to conceptualize cases with the severely mental ill for both the experience and inexperience therapist, (2) educate MFT's how the use of the principles can help reduce symptoms for the consumers, (3) utilize the language of ROC principles, and (4) attend trainings that foster the development of ROC principles in programs. The program allows for MFT's to learn the importance of collaboration and being able to identify individuals that work with the consumer (include the different systems they interact with at the family, clinical, and community level). There is room for MFT'S to learn the importance of case management and how it is beneficial with consumers. The program validates the ideas supervisors have around ROC and promotes the use of principles in treatment.

There is implication for the program being able to offer MFT's the opportunity to receive continuing education unit (CEU) for supervisors in order to train their supervisee. Supervisors can learn how other MFT'S in the field use systems theory to effectively work with consumers. As well as be part of a learning environment where they can learn from clinicians outside of their field as to how they are using ROC in their work. Furthermore, supervisors can learn how to develop programs or groups that include peer-relationship such as clubhouses or wellness centers. This training can be disseminated to other MFT's across the state of CA as well as throughout the United States

Future Research

The clarification of ROC will help to fill the gap in the literature on the application of ROC principles in supervision process. By so doing, those that are trying to adopt the approach will be able to conceptualize how to use the approach effectively. Future research can be used to establish a standard approach on how to adapt ROC to the field of

mental health. Further research can be done in order to inform program developers and evaluators how to develop training programs across the state and outside of the state on how to effectively and efficiently treat consumers.

There are opportunities to do further research on the parallel process of ROC supervision by doing qualitatively interviews with supervisors and supervisees. Future research can also answer the question, how does the learning environment of ROC supervisors affect their use of the principles? Further research can be done at the administrative level of MHSA funded programs to explore how ROC programs are run. Other approaches of the training could also be developed, such as teaching supervisors and supervisee how to do home visits when using ROC.

Recommendations

The U-ROC clinical supervisor training program is developed for clinical supervisors who are supervising in a MHSA funded program. In its present form, the U-ROC training program is a 4-hour, one day training program in which supervisors have to be present the entire time in order to learn the material presented. After analysis of the program, the following recommendations are offered in an effort to further develop training programs around ROC and supervision. First there should be an extension of the U-ROC training program. By extended the program it allows for participants to conceptualize the information effectively, gives enough time for the trainer to train supervisors on the roots of ROC and the meaning of each principle, allows for the trainer to spend more time on each principle and allow participants to ask questions and have discussion without having to rush. Additionally the extension of the training program will educate supervisors on how to utilize the approach in their supervision, allow for extensive conversation around

the issue of countertransference and responsibility and the ability to incorporate more experiential activities (role playing, small group discussions, vignettes).

The second recommendation would be to incorporate how clinical supervisors can help in build the confidence level of supervisees using ROC in their work with consumers. Third, empower supervisors with the knowledge that they already have the necessary tools to function as a ROC supervisor. Additionally teaching supervisors how to use parallel process and the use of metaphors in their supervision to assist supervisees in learning ROC. Using parallel process allows for supervisors to develop mutual relationships with their supervisees, value the goals of supervisees, create and model boundaries in supervision and teach supervisees how to develop boundaries with consumers, as well as model how to use appropriate self disclosure.

The fourth recommendation is to develop a training manual that supervisors can refer to in the future. By doing so this will help with supervisors being able to retain information and have a reference guide after the training. Fifth, incorporate a piece of the training for participants who are peer supporters or peer support supervisors. By incorporating peer supporters in the training they help validate participants ideas and give extra resources and tools during the training. Sixth, provide continuing education units in order to increase buy-in from supervisors.

The formative evaluation process informs the above recommendations for the U-ROC supervisor clinical training program. Formative evaluation is an on going process in which the evaluator is constantly in contact with the stakeholder. In this program the stakeholders are the supervisors that participated in the needs assessment and the training program. It would be recommended that if the stakeholders were willing to continue

learning and being trained in ROC that the evaluator shares the results and development of new programs with them. It is important that the supervisors continue to practice ROC beyond the training program. It is recommended that the program developers provide supervisors with either resources or concrete ways to find those resources. Finally, the U-ROC training program continues to develop and use assessment tools in order to measure program sustainability and effectiveness.

References

- American Association for Marriage and Family Therapy. Retrieved on September 11, 2012. From http://www.aamft.org/imis15/content/supervision/Becoming_Supervisor.aspx.
- Aponte, H.J., & Carlsen, C.J. (2009). An instrument for person-of-the therapist supervision. *Journal of Marital and Family Therapy*, 35(4), 395–405
- Association of State and Provincial Psychology Boards, Task Force on Supervision Guidelines. (1998). *Final Report of the ASPPB Task Force on Supervision Guidelines*. Montgomery, AL: Author.
- Avieneri, A., Davis, S., Loewy, O., Read, M. M., & Wexler, K. (2010). *The Transformed Supervisor: Clinical supervision in California public mental health*. American Association of Marriage and Family Therapy, California Division: Author.
- Baddley, A.D. (2000). The episodic buffer: A new component of working memory? *Trends in Cognitive Science*, 4(11), 417-423.
- Berk, L.E. (2000). *Child Development* (5thed). Boston: Allyn and Bacon.
- Berk, R.A., & Rossi, P.H. (1999). *Thinking about program evaluation* (2ed.). Thousand Oaks, CA: Sage Publications.
- Bernard, J. M., & Goodyear, R. K. (2004). *Fundamentals of clinical supervision* (3rd ed.). Needham Heights, MA: Allyn & Bacon.
- Bernard, J. R. & Goodyear, R. K. (2009). *Fundamentals of clinical supervision* (4thed.) Boston: Pearson Allyn & Bacon.
- Board of Behavioral Sciences. www.bbs.ca.gov

- Borders, D. L., & Cashwell, C. S. (1992). Supervision regulations in counselor licensure legislation. *Counselor Education & Supervision, 31*(4).
- Borg, M., & Kristiansen, K. (2004). Recovery-oriented professionals: Helping relationships in mental health services. *Journal of Mental Health, 13*(5), 493-505.
- Bowen, M. (1972). Toward a differentiation of a self in one's family. In James L. Framo (Ed.), *Family interaction* (pp. 111–173). New York: Springer.
- Bradley J. L., & Kottler, J. A. (2001). Overview of counselor supervision. In J. L. Bradley & N. Ladany (Eds.), *Counselor supervision: Principles, process, and practice* (3rd ed., pp. 3-21). Philadelphia: Brunner-Routledge.
- Caligor, L. (1984). Parallel and reciprocal processes in psychoanalytic supervision. *Contemporary Psychoanalysis, 17*, 1-27.
- Carroll, M. (1995). *Counseling supervision: Theory, skills, and practice*. Cassell, London.
- Carroll, M. (2007). One more time what is supervision? *Psychotherapy in Australia, 13*(3), 34-40.
- Cashin, C., Scheffler, R., Felton, M., Adams, N., & Miller, L. (2008). Transformation of the California mental health system: Stakeholder-driven planning as a transformational activity. *Psychiatric Services, 59*(10), 1107–1114.
- Cassady, J., & Johnson, R. (2000). Cognitive test anxiety and academic performance. *Contemporary Educational Psychology, 21*, 485-490.
- Chamberlin, J. 1990. "The ex-patients' movement: Where we've been and where we're going." *Journal of Mind and Behavior, 11*(3&4), 323[77] – 336[90].

- Charmaz, K. (2006). Grounded theory - Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 249-291). London: Sage.
- Cone, J.J. (2001). *Evaluating outcomes: Empirical tools for effective practice*. Washington, D.C: American Psychology Association.
- Conner, R. (2005). "The Colorado healthy communities initiatives." *American Journal of Evaluation*, 26(3), 363-377.
- Cronbach, L.J. (1982). *Designing evaluations of educational and social programs*. San Francisco, CA: Jossey-Bass Inc., Publishers.
- Crocket, K., Gaddis, S., Day, C., Flintoff, V., Lammers, M., Malcolm, P., et al. (2007). Shaping supervision practice through research: Effects of supervision for counseling practice. *New Zealand Journal of Counseling*, 27(1), 55–69.
- Daly, K. J. (2007). *Qualitative methods for family studies and human development*. Los Angeles, CA: Sage. (Pages 153-155).
- Davidson, L. (2003). *Living outside mental illness. Qualitative studies of recovery in schizophrenia*. New York: New York University Press.
- Davidson, L., O'Connell, M.J., Tondora, J., Lawless, M., & Evans, A.C. (2005). Recovery in serious mental illness: A new wine or just a new bottle? *Professional Psychology: Research and Practice*, 36(5), 480-487.
- Davidson, L., Kirk, T., Rockholz, P., Tondora, J., O'Connell, M.J. & Evans, A.C. (2007). Creating a recovery- oriented system of behavioral health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal*, 31(1): 23-31.

- Department of Health and Human Services: Substance Abuse and Mental Health Services Administration (2003). *Achieving the Promise: Transforming mental health care in America*. The President's New Freedom Commission on Mental Health.
- Edgar, L.C.J., Angera, J.J., & Hakoyama, M. (2008). Transferable principles from a formative evaluation of a couples' empathy program. *Journal of Couples & Relationship Therapy*, 7(2), 88-112.
- Ellis, M. V. (2010). Bridging the Science and Practice of Clinical Supervision: Some discoveries, some misconceptions. *Clinical Supervisor*, 29(1), 95-116.
- Everett, B. 2000. *A fragile revolution: Consumers and psychiatric survivors confront the power of the mental health system*. Waterloo, Ontario: Wilfrid Laurier University Press.
- Executive order. (2002). President's new freedom commission on mental health. Retrieved from [http:// nodis3.gsfc.nasa.gov/displayEO.cfm?id=EO_13263_](http://nodis3.gsfc.nasa.gov/displayEO.cfm?id=EO_13263_)
- Falender, C. A., & Shafranske, E. P. (2004). *Clinical Supervision: A competency-based approach*. Washington, DC: American Psychological Association.
- Felton, M.C., Cashin, C.E., & Brown, T.T. (2010). What does it take? California county funding requests for recovery-oriented full service partnerships under the mental health services act. *Community Mental Health Journal*, 46, 441–451
- Fardella, J. A. (2008). The recovery model: Discourse ethics and the retrieval of the self. *Journal of Medical Humanities*, 29, 111-126.
- Fink, A. (1995). *Evaluation for education and psychology*. Thousand Oaks, CA : Sage Publications.

- Fisher, D. & Ahern, L. (n.d.). *Spirituality and recovery from mental disorders*. Retrieved on August 21, 2012 from <http://www.spiritualcompetency.com/recovery/lesson1.html>.
- Fournier, D. M. (2005). "Evaluation." In S. Mathison. *In encyclopedia of evaluation*. Thousand Oaks: Sage Publication.
- Franke, A., & Arvidsson, B. (2011). Research supervisors' different ways of experiencing supervision of doctoral students. *Studies in Higher Education*. 36(1). 7-13.
- Frese, F.J., Stanley, J., Kress, K., & Vogel-Scibilia, S. (2001). Integrating evidence-based practices and the recovery model. *Psychiatric Services*, 52(11), 1461-1468.
- Freud, S. (1964). Analysis terminable and interminable. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. XXIII, p. 249). London: Hogarth Press. (Original work published 1937).
- Gerard, L. Hein, S.F. & Stuart, C.L. (2009). A qualitative investigation of supervisees' experiences of triadic supervision. *Journal of Counseling & Development*, 87, 449-457.
- Girdano, D.A. (1986). *Occupational health promotion: A practical guide to program development*. New York: Macmillian Publishing.
- Greben, S.E. (1991). Interpersonal aspects of the supervision of individuals psychotherapy. *American Journal of Psychotherapy*, 45, 306-316.
- Gross, S.M. (2005). Students perspective on clinical and counseling psychology practica. *Professional Psychology: Research and Practice* 36, 299-306.

- Hanson, W.E., Creswell, J.W., Clark, V.L.P., Petska, K.S., & Creswell, J.D. (2005). Mixed methods research designs in counseling psychology. *Journal of Counseling Psychology*, 52(2), 224-235.
- Haynes, R., Corey, G., & Moulton, P. (2003). *Clinical supervision in the helping professions: A practical guide*. Pacific Grove, CA: Brooks/Cole.
- Henderson, C.E., Cawyer, C.S., & Watkins, C.E. Jr. (1999). A comparison of student and supervisor perception of effective practicum supervision. *The Clinical Supervisor*, 18, 47-74.
- Hosp, J.L. (2012). Formative evaluation: Developing a framework for using assessment data to plan instruction. *Focus on exceptional children*, 44(9), 2-11.
- Issel, L. M. (2009). *Health program planning and evaluation: A practical, systematic approach for community health* (2nd ed.). Sudbury, MA: Jones and Bartlett Publication.
- Jacobson, N. & Greenly, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services*, 52(4), 482-485.
- Johnstone, P.L. (2004). Mixed methods, mixed methodology health services research in practice. *Qualitative Health Research*, 14(2), 259-271
- Kapp, S.A., & Anderson, G. R. (2010). *Agency-based program evaluation lessons from practice*. Thousand Oaks, CA: Sage Publications.
- Kealey, E. (2010). Assessment and evaluation in social work education: Formative and summative approaches. *Journal of Teaching In Social Work*, 30, 64–74.

- Kettner, P.M., Moroney, R.M., & Martin, L.L. (2008). *Designing and managing programs: An effectiveness-based approach* (3rd ed.). Thousand Oaks: Sage Publications.
- Hicks, J.L., Starns, J.J., 2004. Retrieval-induced forgetting occurs in tests of item recognition. *Psychology Bulletin*, 11, 125–130.
- Issel, L. M. (2009). *Health program planning and evaluation: A practical, systematic approach for community health* (2nd ed.). Sudbury, MA: Jones and Bartlett Publication
- Itzhaky, H., & Chopra, M. (2005). Hope in supervision of therapy of patients with psychotic disorders. *Psychoanalytic Social Work*, 12(2), 63-82.
- Itzhaky, H., & Stern, L. (1996). The take-over of parent-child dynamics in a supervision relationship: Identifying the role transformation. *The Clinical Supervisor*, 14, 65-76.
- Jerrell, J. M., Cousins, V. C., & Roberts, K. M. (2006). Psychometrics of the recovery process inventory. *Journal of Behavioral Health Services & Research*, 33(4), 464-473.
- Joel, M., Pu, Z., Wiegert, O., Oitzl, M.S., & Kruger, H.J. (2006). Learning under stress: how does it work? *Trends in Cognitive Science*, 10(4), 152-158.
- Jones, A. (1998). Clinical supervision with community macmillan nurses: Some theoretical suppositions and case work reports. *European Journal of Cancer Care*, 7, 63–69.
- Jones, A. (1998). Some reflections on clinical supervision: an existential phenomenology paradigm. *European Journal of Cancer Care*, 7, 56-62.

- Jones, A. (2006). Clinical supervision: what do we know and what do we need to know? A review and commentary. *Journal of Nursing Management* 14, 577–585.
- Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 62(6), 617-27.
- Ladany, N. (2002). Psychotherapy supervision: How dress is the emperor? *Psychotherapy Research*, 37, 14-18.
- Ladany, N. (2004). Psychotherapy supervision: what lies beneath. *Psychotherapy Research*, 14, 1-19.
- Ladany, N., Hill, C.E., Corbett, M.M., & Nutt, E.E. (1996). Nature, extent and importance of what psychotherapy trainees do not disclose to their supervisors. *Journal of Counselling Psychology*, 34, 220-231.
- Lee, J.H. (1999). Test anxiety and working memory. *Journal of Experimental Education*, 67(3), 187-218.
- Lee, R. E., Nichols, D. P., Nichols, W.C., & Odom, T. (2004). Trends in family therapy supervision: The past 25 years and into the future. *Journal of Marital and Family Therapy*. 30(1), 61-69.
- Levine, B. E. 2001. *Commonsense rebellion: Debunking psychiatry, confronting society*. New York: Continuum.
- Levine, E.S. (2012). Facilitating recovery for people with serious mental illness employing a psychobiosocial model of care. *Professional Psychology: Research and Practice*, 45(1), 58-64.

- Lynch, M.A. (2004) Long-term potentiation and memory. *Physiology. Revelation*, 49(84), 87–136.
- McKeachie, W.J., (1986). Teaching Tips: A guidebook for the beginning college teacher (8th ed). Lexington, MA: Heath.
- Mearns, D. (1993). On being a supervisor. In Dryden, W. & Thorne, B. *Training and supervision for counseling in actions*. Sage Publication, London.
- Morrison, L. 2000. “Committing social change for psychiatric patients: The consumer/survivor movement. *Humanity & Society* 24, 389-404.
- Mental health commission. (2005). President's new freedom commission on mental health. Retrieved from <http://govinfo.library.unt.edu/mentalhealthcommission/contactus.html>
- Mental Health Services Act. (2004). California department of mental health. Retrieved August 20, 2012. http://www.dmh.ca.gov/prop_63/MHSA/docs/Mental_Health_Services_Act_Full_Text.pdf
- National institute of mental health. (2002). The numbers count: mental disorders in america. Retrieved from <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml>.
- Netting, F., Kettner, P., & McMurty, S. (2008). Social work macro practice (4th ed.). Boston: Allyn & Bacon.
- Olk, M., & Friedlander, M.L. (1992). Trainees’ experiences of role conflict and role ambiguity in supervisory relationship. *Journal of counseling Psychology* 39, 389-397.

- Omand, L. (2010). What makes for good supervision and whose responsibility is it anyway?. *Psychodynamic Practice*, 16(4), 377-392.
- Omark, R. 1979. "The dilemma of membership in recovery, Inc., a self-help mental patients' organization. *Psychological Reports*, 44(3), 1119-1125
- Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. A. (n.d.). An analysis of the definitions and elements of recovery: A review of the literature.
- Ortega-Castro, N., and Vadillo, M.A. (2012). Retrieval-induced forgetting and interference between cues: Training a cue–outcome association attenuates retrieval by alternative cues. *Behavioral Processes*, 94, 19-25.
- Patton, D. (2005). Social inclusion and recovery: A model for mental health practice. *Journal of Psychiatric & Mental Health Nursing*, 12(3), 383-384. Retrieved on August 10, 2012, from Academic Search Premier Database.
- Patton, M.Q. (2008). *Utilization-focused evaluation* (4th ed.). Thousand Oaks, CA: Sage Publication.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods*, (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Pearson, Q. M. (2006). Psychotherapy-driven supervision: Integrating counseling theories into role-based supervision. *Journal of Mental Health Counseling*, 28(3), 241-252.
- Pir, T. (2009). The transformation of Traditional Mental Health Service Delivery in multicultural society in California, USA, that can be replicated globally. *Counselling Psychology Quarterly*, 22(1), 33–40

- Porter, R. 1987. *A social history of madness: The world through the eyes of the insane*. New York: E.P. Dutton.
- Posavac, E.J. & Carey, R.C. (2003). *Program evaluation methods and case studies* (6th ed.). New Jersey: Prentice Hall.
- Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The de facto mental and addictive disorders service system. Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, 50(2), 85-94.
- Rich, P. (1993). The form, function and content if clinical supervision: An integrated model. *The Clinical Supervisor*, 11, 137-138.
- Rickards, H., Rogers, R., Ellis, N., Beidelman, W. (1988). Some retention but not enough. *Teaching in Psychology*, 15, 151-52.
- Rist, R.C. (2006). "The 'e' in monitoring and evaluation: using evaluative knowledge to support a result-base management system." In R.C., Rist & N. Stame. *From studies to streams: Managing evaluative systems*. New Brunswick, NJ: Transaction Books.
- Roediger, H.L., & Butler, A.C. (2010). The critical role of retrieval practice in long-term retention. *Trends in Cognitive Science*, 30(10), 1-8.
- Ronnestad, M. H. & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of Career Development*, 30, 5-44.
- Rossi, P.H. & Williams, W. (1972). *Evaluation social programs: Theory, practice, and politics*. New York, New York: Seminar Press.

- Rossi, P. H., Freeman, H. E. & Lipsey, M. W. (1999). *Evaluation a systematic approach* (6th ed.). Thousand Oaks, CA: Sage Publications
- Royse, D., Thyer, B.A., & Padgett, D.K. (2010). *Program evaluation an introduction* (5th ed.). Belmont, CA: Wadsworth, Cengage learning.
- Scheff, T. J. 1999. *Being mentally ill: A sociological theory*. (3rd ed.). New York: Aldine deGruyter.
- Scheffler, R., & Adams, N. (2005). Millionaires and mental health: Proposition 63 in california. *Health Affairs*, 25, 212–224.
- Scholinski, Daphne. 1997. *The last time i wore a dress: A Memoir*. New York: Riverhead Books.
- Scott, J. C. 1985. *Weapons of the weak: Everyday forms of peasant resistance*. New Haven, CT: Yale University Press.
- Scott, K., Ingram, K., Vitanza, S., and Smith, N. (2000), Training in Supervision: A Survey of Current Practices. *The Counseling Psychologist*, 28, 403-422.
- Scriven, M. (1999). The fine line between evaluation and explanation. *Research on Social Work Practices*, 9, 521-524.
- Sells, D. J., Stayner, D. A., Davidson, L. (2004). Recovering the Self in Schizophrenia: An Integrative Review of Qualitative Studies. *Psychiatric Quarterly*, 75, 87-97.
- Sheridan, S., & Williams, P. (2011). Developing individuals goals, shared goals, and the goals of others: Dimensions of constructive competition in learning contexts. *Scandinavian Journal of Educational Research*, 55(2), 145-164.

- Sowers, W. Transforming systems of care: The American Association of Community Psychiatrists guidelines for recovery oriented services. *Community Mental Health Journal*, 41(6), 757-774.
- Strauss, A. & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Sussman, S. (2001). *Handbook of program development for health behavior research and practice*. Thousand Oaks, CA: Sage Publications.
- Szasz, Thomas. 2001. *Pharmacracy: Medicine and Politics in America*. Westport, CT: Praeger.
- Taylor, C., Gibbon, F., & Morris, L.L. (1987). *How to design a program evaluation*. Newbury, CA: Sage Publications.
- Timmreck, T.C. (2003). *Planning, program development, and evaluation: A handbook for health promotion, aging, and health services* (2nd ed.). Sudbury, MA: Jones and Bartlett Publishers.
- Todd, T.C., & Storm, C.L. (1997). Thoughts on the evolution of mft supervision. In T.C. Todd & C. L. Storm (eds.). *The complete systemic supervisor* (pp. 1-16). Allyn & Bacon: New York, New York.
- Tondora, J., & Davidson, L., (2006). *Practice guidelines for recovery-oriented behavioral health care*. Harford, CT: Department of Mental Health and Addiction Services.
- U.S. census bureau population estimates by demographic characteristics. Table 2: Annual estimates of the population by selected age groups and sex for the united states:

April 1, 2000 to July 1, 2004 (NC-EST2004-02) Source: Population Division,
U.S. Census Bureau Release Date: retrieved August 26, 2012.

<http://www.census.gov/popest/national/asrh/>

United States Department of Health and Human Services. (n.d.). National consensus statement on mental health recovery. *Substance Abuse and Mental Health Services Administration Center for Mental Health Services*. Retrieved on August 19, 2012, from <http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/>.

U.S. Department of Health and Human Services. Mental health: A report of the surgeon general—executive summary. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

United States Department of Justice (1990). *Americans with Disabilities Act of 1990*.42 U.S.C. §§ 12101 et seq.

Watkins, C.E. (1996). On demoralization and awe in psychotherapy supervision. *The Clinical Supervisor*, 14, 139-149.

Watkins, C. E. (1999). The beginning psychotherapy supervisor: How can we help? *The Clinical Supervisor*, 18(2), 63-70.

Weston, C., LeMaistre, C., McAlpine, L., & Bordonaro, T. (2004). The influences of participants in formative evaluation on the improvement of learning from written instructional materials. *Instructional Science*, 25, 369-386.

Whitaker, Robert. 2002. *Mad in america: Bad science, bad medicine, and the enduring mistreatment of the mentally ill*. Cambridge, MA: Perseus Publishing.

Williams, A., Turrell, p., and Wall, R. (2002). Let's TWIST: Creating a conducive learning environment for women. *International Journal of Engineering Education*, 18(4), 447-451.

Worthen, V.E., & Isakson, R.L. (2000). Supervision outcome survey. Unpublished scale

Zinman, Sally, Howie the Harp, Su Budd (eds.). 1987. *Reaching across: Mental health clients helping each other*. Sacramento, CA: California Network of Mental Health Clients

APPENDIX A

**CLINICAL SUPERVISION IN RECOVERY ORIENTED CARE
RECRUITMENT LETTER**

Dear Supervisor,

My name is Dr. Winetta Baker. I am a professor at Loma Linda University and am conducting a study focusing on supervisors' use of Recovery-Oriented Care principles. We are not asking for agency participation but we would like to better understand the ways in which supervisors incorporate the principles of Recovery-Oriented Care into their work with supervisees treating the severely mentally ill. Participation will involve a face-to-face interview where you respond to questions about how you conduct supervision. The interview will take approximately 30 minutes and can be held at a time and place of your convenience.

To participate in this study, you only need to have supervised at least one trainee/intern who worked with at least one severely mentally ill client within the past year. No supervisor will be identified or discussed in report and no confidential information will be solicited from you and/or will be disclosed. We are kindly asking for your support in this effort and would like to meet with you for approximately 30 minutes to ask some questions about your supervisory practices. If you are willing to hear more or to participate in an interview, please contact me via email at wbaker@llu.edu or via phone at (909) 558-4547x42099.

Sincerely,

Winetta Baker

APPENDIX B

NEEDS ASSESSMENT INFORMED CONSENT



LOMA LINDA UNIVERSITY

School of Science and Technology

You are invited to participate in this study as you supervise or have supervised trainees/interns who provide treatment to severely mentally ill clients within the California public mental health system. As you may already know, in 2004 Californians voted to institute a tax on persons earning over \$1,000,000. This tax, which is now referred to as the Mental Health Services Act (MHSA) provides one penny for every dollar earned over \$1,000,000 to fund Recovery-Oriented Care services for individuals who have previously been unserved and/or underserved. Since 2004, recovery-oriented care has begun to transform the way students in behavioral science professions are taught, mental health clinicians are conceptualizing treatment and clinical supervision is performed. As a person who provides supervision, you are invited to participate in a study of how you incorporate recovery-oriented care principles into your work with supervisees.

Purpose

This study seeks to clarify the ways in which clinical supervisors incorporate Recovery-Oriented Care principles into their work with students and interns.

Procedures

Participation will involve responding to questions during a face-to-face interview. These questions will focus on the tools that you use to incorporate Recovery-Oriented Care principles into your clinical supervision. It is anticipated that the entire interview will last approximately 30 minutes. You have the right to terminate your participation at any point during the interview.

Confidentiality

Should you decide to participate in this study, your interview will be audio recorded. Audio recordings will be transcribed within two weeks of your interview. At the time of transcription, all identifying information about you will be removed and will either be replaced with a non-identifying code system, or left out of the transcript.

Initial: _____

After the transcriptions are verified for accuracy with the audio recording, these recordings will be destroyed. Audio recordings will be destroyed within 60 days following your interview. Following removal of identifying information, responses will be evaluated by members of this research team. All responses will be stored in the Research Building of the Counseling and Family Sciences Department at Loma Linda University.

During the interview, you are encouraged to avoid discussing specific supervisees or clients by name so as to maintain confidentiality. If you must discuss a particular supervisee or client, please utilize a pseudonym and avoid using any identifying information.

Voluntary

Your participation in this study is your choice. You have the right to not participate in this study and there will be no penalty if you decide to exercise this right.

Possible Risks or Benefits

There are no foreseeable risks identified in your participation of this study outside of a possible breach of confidentiality. As indicated above, several measures will be taken to protect you and maintain privacy, making this risk minimal.

Critically considering your work as a supervisor may be a benefit to you in better recognizing your areas of strength as well as improving the clinical skill of your supervisees.

If you have any questions or concerns about this study, please contact Winetta Baker at (909) 558-4547 x42099. Should you have any complaints about participation in this study, please contact LLU Office of Patient Relations at office of patient relations at 909-558-4647 or email patientrelations@llu.edu.

Consent Statement

I have read the information above and have listened to the verbal explanation given by the member of the research team. My questions concerning this study have been answered to my satisfaction. I hereby give voluntary consent to participate in this study. Signing this consent document does not waive my rights nor does it release the investigators or institution from their responsibilities.

Printed name of Participant

Signature of Participant

Date

I have reviewed all sections of the informed consent form the person signing above. I have explained potential risks and benefits.

Printed name of Study Personnel

Signature of Study Personnel

Date

APPENDIX C

CLINICAL SUPERVISION IN RECOVERY ORIENTED CARE BACKGROUND INFORMATION DEMOGRAPHIC INFORMATION

1. Level of Education
☐ Masters
☐ Doctorate
2. What is your ethnicity?
☐ White
☐ Black
☐ Hispanic
☐ Other
3. What is your age?
☐ 20-30
☐ 31-40
☐ 41-50
☐ 51-60
☐ 61-70
☐ 71-80
☐ 81-90
4. How long have you been licensed? _____
5. What type of professional license(s) do you hold?
☐ MFT
☐ LCSW
☐ Psychology
☐ MD/Psychiatrist
6. What is your supervisory status?
☐ AAMFT approved supervisor
☐ AAMFT approved supervisor in training
☐ Board of Behavioral Sciences approved supervisor
7. Currently, what form of supervision do you provide at your agency?
☐ Individual
☐ Group
☐ Both
8. What theoretical model do you utilize most often?
9. What theoretical model did your most influential clinical supervisor utilize most often?

Agency Information

1. In what city is your agency located?
2. What sources of funding does your agency accept?
____ MHS
____ State/County Programs
____ MediCal
____ Other
3. Approximately what percentage of clients served at your agency are:
Age: ____ under 16 ____ 16-25 ____ 26 – 40 ____ 41-60 ____ 61 and
over Socioeconomic Status: ____ Upper ____ Middle ____ Lower
Ethnicity: ____ White ____ Black ____ Hispanic ____ Asian
____ Other

Clinical Supervision in Recovery-Oriented Care Interview Guide

General

1. As a supervisor, what is your understanding of the word ‘consumer’?
2. What is your understanding of recovery-oriented care?

Self-Direction

3. There may be many ways to communicate to your supervisee that the consumer determines her/his own recovery. In what ways do you encourage or support your supervisees to allow consumers to determine their own path of recovery?

Individualized and Self-Centered

4. How do you work with your supervisees to promote the individual strengths and uniqueness of each consumer?

Empowerment

5. When working with supervisees, what are the ways that you support consumers participating in the decisions that affect their own lives?

Responsibility

6. Please share with me your thoughts about who is responsible for change in the therapist-consumer relationship?

7. How do these thoughts come to life in your supervisory relationships?

Holistic

8. To the extent that persons with severe mental illness often present with needs in multiple areas, e.g. housing and employment, how do you help your supervisee to be a resource for consumers in all areas of need?

Non-linear

9. Clinicians who work with the severely mentally ill tend to develop an understanding that there may be ups and downs in the process of change. As a supervisor, how do you communicate that growth is a continuing experience that is often accompanied by setbacks and apparent failures?

Strengths-Based

10. During supervision, how do you assist your supervisees in developing and maintaining an outlook of the consumer as being resilient, that is, having multiple capacities, talents and coping skills?

Peer-Support

11. Participating in the recovery of others may go a long way in helping to solidify consumers' own recovery. How might you say you are able to help your supervisees to explore these possibilities with their consumers?

Respect for the consumer

12. As a supervisor, what does the term "respect for the consumer" mean to you?
13. How does this meaning show itself in conversations with your supervisees?

Hope

14. What is your belief about the ability of consumers to live with severe mental illness?
15. Please share the ways in which you help your supervisees to understand and communicate the message that people can and do overcome their obstacles?

General

How would you rate the importance of each of the following principles in treating severely mentally-ill persons?

Extremely	Not	Low	Slightly	Neutral	Moderately	Very
16. Self-Direction 7	1	2	3	4	5	6
17. Person-Centered 7	1	2	3	4	5	6
18. Empowerment 7	1	2	3	4	5	6
19. Responsibility 7	1	2	3	4	5	6
20. Holistic Care 7	1	2	3	4	5	6
21. Non-linear Care 7	1	2	3	4	5	6
22. Strengths-Based 7	1	2	3	4	5	6
23. Peer-Support 7	1	2	3	4	5	6
24. Respect for Consumer 1 7		2	3	4	5	6
25. Hope 7	1	2	3	4	5	6

APPENDIX D

THE U-ROC CLINICAL SUPERVISION TRAINING PROGRAM DEMOGRAPHIC INFORMATION

Name: _____

Level of Education	What is your ethnicity?	What is your age?	How long have you been licensed? _____
<input type="checkbox"/> Masters	<input type="checkbox"/> White	<input type="checkbox"/> 20-30	
<input type="checkbox"/> Doctorate	<input type="checkbox"/> Black	<input type="checkbox"/> 31-40	
	<input type="checkbox"/> Hispanic	<input type="checkbox"/> 41-50	
	Asian/Pacific Islander	<input type="checkbox"/> 51-60	
	<input type="checkbox"/> Other	<input type="checkbox"/> 61-70	
		<input type="checkbox"/> 71-80	
		<input type="checkbox"/> 81-90	

<p>What type of professional license(s) do you hold?</p> <p> <input type="checkbox"/> MFT <input type="checkbox"/> LCSW <input type="checkbox"/> Psychology <input type="checkbox"/> MD/Psychiatry <input type="checkbox"/> Other </p>	<p>What is your supervisory status?</p> <p> <input type="checkbox"/> AAMFT approved supervisor <input type="checkbox"/> AAMFT approved supervisor in training <input type="checkbox"/> CAMFT approved supervisor <input type="checkbox"/> AAMFT approved supervisor in training <input type="checkbox"/> Board of Behavioral Sciences approved supervisor </p>	<p>Currently, what form of supervision do you provide at your agency?</p> <p> <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Both </p>	<p>In what city is your agency located?</p>
<p>What sources of funding does your agency accept?</p> <p> <input type="checkbox"/> MHSA <input type="checkbox"/> State/County Programs <input type="checkbox"/> MediCal <input type="checkbox"/> Other </p>	<p>Approximately what percentage of clients served at your agency are:</p> <p>Age:</p> <p> <input type="checkbox"/> % Children <input type="checkbox"/> % Transitional age youth <input type="checkbox"/> % Adults <input type="checkbox"/> % Older adults </p>	<p>Approximately what percentage of clients served at your agency are:</p> <p>Socioeconomic Status:</p> <p> <input type="checkbox"/> % Upper <input type="checkbox"/> % Middle <input type="checkbox"/> % Lower </p>	<p>Approximately what percentage of clients served at your agency are:</p> <p>Ethnicity:</p> <p> <input type="checkbox"/> % White <input type="checkbox"/> % Black <input type="checkbox"/> % Hispanic <input type="checkbox"/> % Asian <input type="checkbox"/> % Other </p>

APPENDIX E

Name _____

Agency _____

The U-ROC Pretest

Thank you for attending this training. This pretest, along with the posttest, is meant as an evaluation of the training's effectiveness. Please read carefully and answer and mark your answers clearly. Your responses will help in shaping future trainings.

2. There are _____ principles in recovery oriented care
 - A. 12
 - B. 10
 - C. 15
 - D. 20
3. The principle self-direction is defined as:
 - A. Consumer working individually on their path to recovery
 - B. Consumer taking the lead over what direction they choose to take with their treatment
 - C. Consumer living on their own and attending treatment
 - D. Clinician directs the consumer on how to address symptoms and treatment
4. Which of the following topics would not be discussed if you are focusing on the principle of holistic care?
 - A. Resources
 - B. Support systems
 - C. Setbacks
 - D. All of the above
5. A supervisor who is helping their supervisee to apply the principal of individualized and self centered care is actually assisting to identify:
 - A. Their own self determination
 - B. Positive characteristics and uniqueness of the consumer
 - C. A holistic approach to treatment
 - D. The DSM diagnoses of the consumer
6. The principle strength based is best defined as:
 - A. Building on the consumer's self determination and abilities
 - B. Building on the inherent worth of trauma, having multiple capacities, and coping abilities
 - C. Building on the qualities of the consumer
 - D. Building on consumer's inner strength to identify their capabilities
7. Which of the following statement is true regarding the empowerment principle?
 - A. Clinicians help motivate the consumer to accomplish their identified goals
 - B. It is the clinician's task to identify the consumer's treatment goals

- C. Clinicians are held responsible for the consumer's level of motivation
 - D. Clinicians are required to use all their learned skills and interventions in empowering consumers.
8. Beverly is in her 2nd year of traineeship. During supervision Beverly shared that she often feels exhausted after working with 1 particular consumer. After exploring what is occurring in the sessions you identify that Beverly is burnt out from this consumers because of her need to save him and make his path to recovery one that is smooth. As a recovery oriented care supervisor, which the following topic would be a fitting discussion to have with Beverly?
- A. Self Determination
 - B. Conflict resolution
 - C. Responsibility of supervisee
 - D. Normalization of sessions
9. Recovery oriented care is intended to be used as a
- A. Treatment model
 - B. Theoretical overlay
 - C. Intervention
 - D. Theory of supervision
10. During supervision a supervisee shares with you that they may not be the best-fit clinician for one consumer on their caseload. They often feel that they are not progressing in the sessions and that the consumer feels stuck. As a supervisor you want to share ways to work with the consumer by applying which of the recovery oriented care principle?
- A. Responsibility
 - B. Strength based
 - C. Non-linear
 - D. Holistic care
11. A supervisee may show respect for their consumer by. Circle all that applies.
- A. Being Non-judgmental
 - B. Honoring their rights
 - C. Accepting consumer values and beliefs
 - D. Complementing
12. The principle hope is best defined as:
- A. Having authority to choose from a wide range of options, consumer participating in all decisions that will affect their lives
 - B. Practitioner communicate the message that people can overcome their obstacles, there is life with mental illness
 - C. Growth is continual, occasional set backs are expected, learning from experience is incorporated.
 - D. Each consumer is whole person so treat the whole person, mind, body, soul, community

13. Your supervisee is interested in utilizing a peer support for her consumer. Which of the following suggestions might you provide?
- A. Ask consumer to join therapeutic group
 - B. Consider option of bringing family into therapy
 - C. Invite consumer to your next supervision meeting
 - D. None of the above

For each of the principles below rate your agreement with this statement. I have a good understanding of this principle.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Self-direction	1	2	3	4	5
Individualized and self centered	1	2	3	4	5
Empowerment	1	2	3	4	5
Responsibility	1	2	3	4	5
Holistic	1	2	3	4	5
Non-linear	1	2	3	4	5
Strength based	1	2	3	4	5
Peer support	1	2	3	4	5
Respect for the consumer	1	2	3	4	5
Hope	1	2	3	4	5

For each of the principles below rate your agreement with this statement. I feel capable of assisting my supervisee in developing their understanding.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Self-direction	1	2	3	4	5
Individualized and self centered	1	2	3	4	5
Empowerment	1	2	3	4	5
Responsibility	1	2	3	4	5
Holistic	1	2	3	4	5
Non-linear	1	2	3	4	5
Strength based	1	2	3	4	5
Peer support	1	2	3	4	5
Respect for the consumer	1	2	3	4	5
Hope	1	2	3	4	5

APPENDIX F

Name _____

Agency _____

The U-ROC Posttest

Thank you for attending this training. This posttest, along with the posttest, is meant as an evaluation of the training's effectiveness. Please read carefully and answer and mark your answers clearly. Your responses will help in shaping future trainings.

1. There are _____ principles in recovery oriented care
C. 12 C. 15
D. 10 D. 20
2. Recovery oriented care is intended to be used as a
C. Treatment model C. Intervention
D. Theoretical overlay D. Theory of supervision
3. The principle self-direction is defined as:
E. Consumer working individually on their path to recovery
F. Consumer taking the lead over what direction they choose to take with their treatment
G. Consumer living on their own and attending treatment
H. Clinician directs the consumer on how to address symptoms and treatment
4. A supervisor who is helping their supervisee to apply the principal of individualized and self centered care is actually assisting to identify:
E. Their own self determination
F. Positive characteristics and uniqueness of the consumer
G. A holistic approach to treatment
H. The DSM diagnoses of the consumer
5. The principle strength based is best defined as:
E. Building on the consumer's self determination and abilities
F. Building on the inherent worth of trauma, having multiple capacities, and coping abilities
G. Building on the qualities of the consumer
H. Building on consumer's inner strength to identify their capabilities
6. Which of the following statement is true regarding the empowerment principle?
E. Clinicians help motivate the consumer to accomplish their identified goals
F. It is the clinician's task to identify the consumer's treatment goals
G. Clinicians are held responsible for the consumer's level of motivation
H. Clinicians are required to use all their learned skills and interventions in empowering consumers.

7. Beverly is in her 2nd year of traineeship. During supervision Beverly shared that she often feels exhausted after working with 1 particular consumer. After exploring what is occurring in the sessions you identify that Beverly is burnt out from this consumers because of her need to save him and make his path to recovery one that is smooth. As a recovery oriented care supervisor, which the following topic would be a fitting discussion to have with Beverly?
- E. Self Determination
 - F. Conflict resolution
 - G. Responsibility of supervisee
 - H. Normalization of sessions
8. Which of the following topics would not be discussed if you are focusing on the principle of holistic care?
- E. Resources
 - F. Support systems
 - G. Setbacks
 - H. All of the above
9. During supervision a supervisee shares with you that they may not be the best-fit clinician for one consumer on their caseload. They often feel that they are not progressing in the sessions and that the consumer feels stuck. As a supervisor you want to share ways to work with the consumer by applying which of the recovery oriented care principle?
- E. Responsibility
 - F. Strength based
 - G. Non-linear
 - H. Holistic care
10. Your supervisee is interested in utilizing a peer support for her consumer. Which of the following suggestions might you provide?
- E. Ask consumer to join therapeutic group
 - F. Consider option of bringing family into therapy
 - G. Invite consumer to your next supervision meeting
 - H. None of the above
11. A supervisee may show respect for their consumer by. Circle all that applies.
- E. Being Non-judgmental
 - F. Honoring their rights
 - G. Accepting consumer values and beliefs
 - H. Complementing
12. The principle hope is best defined as:
- E. Have authority to choose from range of options, consumer participate in all decisions that will affect their lives

- F. Practitioner communicate the message that people can overcome their obstacles, there is life with mental illness
- G. Growth is continual, occasional set backs are expected, learning from experience is incorporated.
- H. Each consumer is whole person so treat the whole person, mind, body, soul, community

13. Has a result of this training my comfort level in utilizing recovery oriented care in supervision as:

- A. Lessened
- B. Increased
- C. Stayed the same

14. Has a result of this training my knowledge on recovery oriented care as:

- A. Lessened
- B. Increased
- C. Stayed the same

Please indicate if you're willing to participate in follow up for this training in a 10-minute online survey. If yes what is your email.

- a. Yes
- b. No

Please indicate if you're willing to participate in future research on recovery-oriented care.

For each of the principles below rate your agreement with this statement. I have a good understanding of this principle.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Self-direction	1	2	3	4	5
Individualized and self centered	1	2	3	4	5
Empowerment	1	2	3	4	5
Responsibility	1	2	3	4	5
Holistic	1	2	3	4	5
Non-linear	1	2	3	4	5
Strength based	1	2	3	4	5
Peer support	1	2	3	4	5
Respect for the consumer	1	2	3	4	5
Hope	1	2	3	4	5

For each of the principles below rate your agreement with this statement. I feel capable of assisting my supervisee in developing their understanding.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Self-direction	1	2	3	4	5
Individualized and self centered	1	2	3	4	5
Empowerment	1	2	3	4	5
Responsibility	1	2	3	4	5
Holistic	1	2	3	4	5
Non-linear	1	2	3	4	5
Strength based	1	2	3	4	5
Peer support	1	2	3	4	5
Respect for the consumer	1	2	3	4	5
Hope	1	2	3	4	5

How likely are you to use these tools from today's training in your supervision?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Questions	1	2	3	4	5
Reflections	1	2	3	4	5
Discussion	1	2	3	4	5
Humanization	1	2	3	4	5
Application	1	2	3	4	5

THE U-ROC SUPERVISOR TRAINING PROGRAM ONLINE SURVEY

Your feedback is important to us, it will help to further improve the U-ROC training program and develop other training programs for clinicians using the principles of recovery oriented care.

1. Please indicate your identification number that was sent to you in the email_____.
2. There are _____ principles in recovery oriented care
 - E. 12
 - C. 15
 - F. 10
 - D. 20
3. Recovery oriented care is intended to be used as a
 - E. Treatment model
 - C. Intervention
 - F. Theoretical overlay
 - D. Theory of supervision
4. The principle self-direction is defined as:
 - I. Consumer working individually on their path to recovery
 - J. Consumer taking the lead over what direction they choose to take with their treatment
 - K. Consumer living on their own and attending treatment
 - L. Clinician directs the consumer on how to address symptoms and treatment
5. A supervisor who is helping their supervisee to apply the principal of individualized and self centered care is actually assisting to identify:
 - I. Their own self determination
 - J. Positive characteristics and uniqueness of the consumer
 - K. A holistic approach to treatment
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 - K. Building on the qualities of the consumer
 - L. Building on consumer's inner strength to identify their capabilities

7. Which of the following statement is true regarding the empowerment principle?
- I. Clinicians help motivate the consumer to accomplish their identified goals
 - J. It is the clinician's task to identify the consumer's treatment goals
 - K. Clinicians are held responsible for the consumer's level of motivation
 - L. Clinicians are required to use all their learned skills and interventions in empowering consumers.
8. Beverly is in her 2nd year of traineeship. During supervision Beverly shared that she often feels exhausted after working with 1 particular consumer. After exploring what is occurring in the sessions you identify that Beverly is burnt out from this consumers because of her need to save him and make his path to recovery one that is smooth. As a recovery oriented care supervisor, which the following topic would be a fitting discussion to have with Beverly?
- I. Self Determination
 - J. Conflict resolution
 - K. Responsibility of supervisee
 - L. Normalization of sessions
9. Which of the following topics would not be discussed if you are focusing on the principle of holistic care?
- I. Resources
 - J. Support systems
 - K. Setbacks
 - L. All of the above
10. During supervision a supervisee shares with you that they may not be the best-fit clinician for one consumer on their caseload. They often feel that they are not progressing in the sessions and that the consumer feels stuck. As a supervisor you want to share ways to work with the consumer by applying which of the recovery oriented care principle?
- I. Responsibility
 - J. Strength based
 - K. Non-linear
 - L. Holistic care
11. Your supervisee is interested in utilizing a peer support for her consumer. Which of the following suggestions might you provide?
- I. Ask consumer to join therapeutic group
 - J. Consider option of bringing family into therapy
 - K. Invite consumer to your next supervision meeting
 - L. None of the above
12. A supervisee may show respect for their consumer by. Circle all that applies.
- I. Being Non-judgmental
 - J. Honoring their rights

- K. Accepting consumer values and beliefs
- L. Complementing

13. The principle hope is best defined as:

- I. Have authority to choose from range of options, consumer participate in all decisions that will affect their lives
- J. Practitioner communicate the message that people can overcome their obstacles, there is life with mental illness
- K. Growth is continual, occasional set backs are expected, learning from experience is incorporated.
- L. Each consumer is whole person so treat the whole person, mind, body, soul, community

14. Since the training, have you used any of the tools presented?

- ☐ Yes
- ☐ No

15. Is there any specific method of the “TIONS” approach that you have used in your supervision after the training? Indicate all that applies.

- ☐ Questions
- ☐ Reflections
- ☐ Discussions
- ☐ Humanizations
- ☐ Applications

16. Which of the following principles have you attempted to use in your supervision since the training? Indicate all that apply.

- ☐ Self direction
- ☐ Peer support
- ☐ Responsibility
- ☐ Holistic
- ☐ Empowerment
- ☐ Hope
- ☐ Non-linear
- ☐ Strength based
- ☐ Respect for consumer
- ☐ Individualized and self centered

17. Since the training, have you made any changes in how you implement recovery oriented care in supervision that is different?

- ☐ yes
- ☐ no

If yes please indicate what those changes are



18. How likely are you to continue using the “TIONS” approach in your supervision?

- ☐ Highly Unlikely
- ☐ Unlikely
- ☐ Neutral
- ☐ Likely
- ☐ Highly Likely

20. For each of the principles below rate your agreement with this statement. I feel capable of teaching my supervisee the following principles after the training

	Strong Disagree	Disagree	Neutral	Agree	Strongly Agree
Self Direction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Individualized and Self Centered	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Empowerment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Responsibility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Holistic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-linear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strength Based	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peer Support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respect for the Consumer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hope	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

21. Please respond to the following statement: to what extent has your knowledge of recovery oriented care principles increased?

	Strongly Decrease	Decrease	Stayed the same	Increase	Strongly Increase
Self Direction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Individualized and Self Centered	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Empowerment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Responsibility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Holistic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-linear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strength Based	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peer Support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respect for the Consumer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hope	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. To what extent have you learned how to incorporate recovery oriented care principles in your supervision.

- ☐ Not at all
- ☐ Barely
- ☐ Neutral
- ☐ Fairly well
- ☐ Very well

23. Which of the recovery oriented care principles do you plan to continue implementing in your supervision?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Self direction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Individualized and Self Centered	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Empowerment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Responsibility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Holistic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-linear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strength Based	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peer Support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respect for the Consumer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hope	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

24. As a supervisor furthering your knowledge of recovery oriented care how did you feel about the length of the training?

- ☐ Too short
- ☐ Short
- ☐ Just right
- ☐ Long
- ☐ Too long

25. Please indicate if you're willing to participate in future research on recovery-oriented care.

- ☐ Yes
- ☐ No